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SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

ROBIN CARNAHAN

SECRETARY OF STATE

MISSOURI REGISTER

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Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at http://www.sos.mo.gov/adrules/pubsched.asp

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The rules are codified in the *Code of State Regulations* in this system—

Title	***Code of State Regulations***	**Division**	**Chapter**	**Rule**
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—The most recent version of the statute containing the section number and the date.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons and findings which support its conclusion that there is an immediate danger to the public health, safety or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

Title 20—DEPARTMENT OF INSURANCE
Division 400—Life, Annuities and Health
Chapter 3—Medicare Supplement Insurance

EMERGENCY AMENDMENT

20 CSR 400-3.650 Medicare Supplement Insurance Minimum Standards Act. The department is amending sections (1)–(10), (12)–(16), (18) and (19) of this rule. The department is deleting section (23) of this rule. This amendment also replaces a portion of the form referred to in paragraph (15)(C)4., which is found on pages 59–60 of 20 CSR 400-3 as published in the *Code of State Regulations*.

PURPOSE: This amendment changes the terms "agent" and "broker"to "insurance producer," and also implements changes necessary to remain consistent with minimum federal standards applicable to Medicare Supplement Insurance.

EMERGENCY STATEMENT: This emergency amendment is necessary to preserve the public welfare of Missouri citizens by ensuring the Missouri Department of Insurance has adequate time, before the effective date of federal legislation on January 1, 2006, to review and approve insurers' Medicare supplement insurance filings that will provide coverage for eligible Missouri residents. As a result, the Missouri Department of Insurance finds an immediate danger to the public welfare and a compelling governmental interest, which requires emergency action. The scope of this emergency amendment is limited to the conditions creating the emergency and complies with the protections extended in the ***Missouri and United States Constitutions****. In developing this emergency amendment, representatives of the insurance industry were consulted. The department believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed May 16, 2005, effective June 1, 2005, expires February 2, 2006.*

(1) Applicability and Scope.

(C) All forms printed with this rule are included herein.

(2) Definitions. For purposes of this rule—

(B) "Bankruptcy" means when a Medicare*[+ Choice]***Advantage** organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state;

(J) "Insurance producer" means a person required to be licensed under section 375.012(6), ***Revised Statutes of Missouri*****, to sell, solicit or negotiate insurance;**

*[(J)]***(K)** "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates;

*[(K)]***(L)** "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended;

*[(L)]***(M)** "Medicare*[+ Choice]***Advantage** plan" means a plan of coverage for health benefits under Medicare Part C as defined in section 1859 found in Title IV, Subtitle A, Chapter 1 of P.L. 105-33, and includes:

1. Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

2. Medical savings account plans coupled with a contribution into a Medicare*[+ Choice]***Advantage** medical savings account; and

3. Medicare*[+ Choice]***Advantage** private fee-for-service plans;

*[(M)]***(N)** "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and health services corporations or health maintenance organizations, other than a policy issued pursuant to a contract under section 1876 of the federal Social Security Act (42 U.S.C. section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare*[;]***. "Medicare supplement policy" does not include MedicareAdvantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCCP) that provides benefits pursuant to an agreement under section 1833(a)(1)(A) of the Social Security Act;**

*[(N)]***(O)** "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer;

*[(O)]***(P)** "Pre-standardized Medicare supplement plan" means a Medicare supplement plan issued prior to July 30, 1992;

*[(P)]***(Q)** "Qualified actuary" means a member of the American Academy of Actuaries;

*[(Q)]***(R)** "Standardized Medicare Supplement Plan" means a Medicare supplement plan issued after July 30, 1992; and

*[(R)]***(S)** "Secretary" means the Secretary of the United States Department of Health and Human Services.

(3) Policy Definitions and Terms. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare

supplement policy or certificate unless the policy or certificate contains definitions or terms which conform to the requirements of this section.

(D) "Health care expenses" means**, for purposes of section (12),** expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. *[Expenses shall not include:*

1. Home office and overhead costs;

2. Advertising costs;

3. Commissions and other acquisition costs;

4. Taxes;

5. Capital costs;

6. Administrative costs; and

7. Claims processing costs.]

(G) "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare **Parts A and B**, to the extent recognized as reasonable and medically necessary by Medicare.

(4) Policy Provisions.

(D)

1. Subject to paragraphs (5)(A)4., 5. and 7. and (6)(A)4. and 5., a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006, shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

2. A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

3. After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

A. The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan and;

B. Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

(5) Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to July 30, 1992. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(A) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this rule.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

4. A "noncancelable," "guaranteed renewable," or "noncancelable and guaranteed renewable" Medicare supplement policy shall not—

A. Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

B. Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

5.

A. Except as authorized by the director, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

B. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subparagraph D. of this paragraph, the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

(I) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(II) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in subsection (6)(B) of this rule.

C. If membership in a group is terminated, the issuer shall—

(I) Offer the certificate holder the conversion opportunities described in subparagraph 5.B. of this subsection; or

(II) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

D. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. **Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.**

7. If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

(6) Benefit Standards for Policies or Certificates Issued or Delivered on or After July 30, 1992. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 30, 1992. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(A) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this rule.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

4. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

5. Each Medicare supplement policy shall be guaranteed renewable.

A. The issuer shall not cancel or nonrenew the policy solely on the grounds of health status of the individual.

B. The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

C. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subparagraph (6)(A)5.E., the issuer shall offer certificate holders an individual Medicare supplement policy which at the option of the certificate holder:

(I) Provides for continuation of the benefits contained in the group policy; or

(II) Provides for benefits that otherwise meet the requirements of this subsection.

D. If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall—

(I) Offer the certificate holder the conversion opportunity described in subparagraph (6)(A)5.C.; or

(II) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

E. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

F. If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. **Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.**

7.

A. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period not to exceed twenty-four (24) months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

B. If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted effective as of the date of termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

C. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal rule) at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan (as defined in section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

*[C.]***D.** Reinstitution of coverages*[—]***as described in subparagraphs (6)(A)7.B. and (6)(A)7.C:**

(I) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(II) Shall provide for **resumption of** coverage which is substantially equivalent to coverage in effect before the date of suspension*[;]***. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension;** and

(III) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(B) Standards for Basic (Core) Benefits Common to *[All Benefit Plans]* **Benefit Plans A–J**. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period.

2. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

3. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of **one hundred percent (100%) of** the Medicare Part A eligible expenses for hospitalization paid at the *[diagnostic related group (DRG) day outlier per diem]* **applicable prospective payment system (PPS) rate,** or other appropriate **Medicare** standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. **The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.**

4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

5. Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(C) Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by section (7) of this rule.

1. Medicare Part A Deductible. Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

2. Skilled Nursing Facility Care. Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day

through the hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

3. Medicare Part B Deductible. Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

4. Eighty Percent (80%) of the Medicare Part B Excess Charges. Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

5. One Hundred Percent (100%) of the Medicare Part B Excess Charges. Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

6. Basic Outpatient Prescription Drug Benefit. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar*[s]* ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare. **The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.**

7. Extended Outpatient Prescription Drug Benefit*[:]***.** Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar*[s]* ($250) calendar year deductible to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare. **The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.**

8. Medically Necessary Emergency Care in a Foreign Country. Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

9. Preventive Medical Care Benefit. Coverage for the following preventive health services*[:]* **not covered by Medicare:**

A. An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph B. and patient education to address preventive health care measures;

[B. Any one (1) or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(I) Fecal occult blood test or digital rectal examination, or both;

(II) Mammogram;

(III) Dipstick urinalysis for hematuria, bacteriuria and proteinuria;

(IV) Pure tone (air only) hearing screening test, administered or ordered by a physician;

(V) Serum cholesterol screening (every five (5) years);

(VI) Thyroid function test;

(VII) Diabetes screening;]

B. Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician;

C. Influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster as medically appropriate; **and**

[D. Any other tests or preventive measures determined appropriate by the attending physician; and]

[E.] **D.** Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars ($120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

10. At-Home Recovery Benefit. Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

A. For purposes of this benefit, the following definitions shall apply:

(I) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;

(II) "Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;

(III) "Home" shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence; and

(IV) "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four (24)-hour period of services provided by a care provider is one (1) visit.

B. Coverage Requirements and Limitations.

(I) At-home recovery services provided must be primarily services which assist in activities of daily living.

(II) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(III) Coverage is limited to—

(a) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment;

(b) The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit;

(c) One thousand six hundred dollars ($1,600) per calendar year;

(d) Seven (7) visits in any one (1) week;

(e) Care furnished on a visiting basis in the insured's home;

(f) Services provided by a care provider as defined in this section;

(g) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(h) At-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight (8) weeks after the service date of the last Medicare-approved home health care visit.

C. Coverage is excluded for—

(I) Home care visits paid for by Medicare or other government programs; and

(II) Care provided by family members, unpaid volunteers or providers who are not care providers.

11. New or Innovative Benefits. An issuer may, with the prior approval of the director, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. **After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.**

(D) Standards for Plans K and L.

1. Standardized Medicare supplement benefit plan "K" shall consist of the following:

A. Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;

B. Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;

C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

D. Medicare Part A deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (6)(D)1.J.;

E. Skilled nursing facility care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph (6)(D)1.J.;

F. Hospice care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph (6)(D)1.J.;

G. Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal rules) unless replaced in accordance with federal rules until the out-of-pocket limitation is met as described in subparagraph (6)(D)1.J.;

H. Except for coverage provided in subparagraph (6)(D)1.I. below, coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph (6)(D)1.J. below;

I. Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

J. Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars ($4,000) in 2006, indexed each year by the appropriate inflation adjustments specified by the secretary of the U.S. Department of Health and Human Services.

2. Standardized Medicare supplement benefit plan "L" shall consist of the following:

A. The benefits described in subparagraphs (6)(D)1.A., B., C., and I.;

B. The benefit described in subparagraphs (6)(D)1.D., E., F., G., and H., but substituting seventy-five percent (75%) for fifty percent (50%); and

C. The benefit described in subparagraph (6)(D)1.J., but substituting two thousand dollars ($2,000) for four thousand dollars ($4,000).

(7) Standard Medicare Supplement Benefit Plans.

(A) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in subsections (6)(B) **and (6)(C)** of this rule.

(C) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through *["J"]* **"L"** listed in this section and conform to the definitions in section (3) of this rule. Each benefit shall be structured in accordance with the format provided in subsections (6)(B)*[and]*, (6)(C)**, and (6)(D)** and list the benefits in the order shown in this section. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

(E) Make-Up of Benefit Plans.

1. Standardized Medicare supplement benefit plan "A" shall be limited to the basic (core) benefits common to all benefit plans, as defined in subsection (6)(B) of this rule.

2. Standardized Medicare supplement benefit plan "B" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible as defined in paragraph (6)(C)1.

3. Standardized Medicare supplement benefit plan "C" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in paragraphs (6)(C)1., 2., 3. and 8. respectively.

4. Standardized Medicare supplement benefit plan "D" shall include only the following: The core benefit (as defined in subsection (6)(B) of this rule), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in foreign country and the at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 8. and 10. respectively.

5. Standardized Medicare supplement benefit plan "E" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in paragraphs (6)(C)1., 2., 8. and 9. respectively.

6. Standardized Medicare supplement benefit plan "F" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (6)(C)1., 2., 3., 5. and 8. respectively.

7. Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (6)(C)1., 2., 3., 5., and 8., respectively. The annual high deductible plan "F"

deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible shall be one thousand five hundred dollars ($1,500) for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12)-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

8. Standardized Medicare supplement benefit plan "G" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 4., 8. and 10. respectively.

9. Standardized Medicare supplement benefit plan "H" shall consist of only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in paragraphs (6)(C)1., 2., 6. and 8. respectively. **The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.**

10. Standardized Medicare supplement benefit plan "I" shall consist of only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in paragraphs (6)*[(B)]***(C)**1., 2., 5., 6., 8. and 10. respectively. **The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.**

11. Standardized Medicare supplement benefit plan "J" shall consist of only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 3., 5., 7., 8., 9. and 10. respectively. **The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.**

12. Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: one hundred percent (100%) of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in subsection (6)(B) of this rule, plus the Medicare part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 3., 5., 7., 8., 9. and 10. respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be fifteen hundred dollars ($1,500) for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12)-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10). **The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.**

(F) Make-up of two (2) Medicare supplement plans mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

1. Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in paragraph (6)(D)1.

2. Standardized Medicare supplement plan "L" shall consist only of those benefits described in paragraph (6)(D)2.

(8) Medicare Select Policies and Certificates. This section shall apply to Medicare Select policies and certificates, as defined in this section.

(I) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

1. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with—

A. Other Medicare supplement policies or certificates offered by the issuer; and

B. Other Medicare Select policies or certificates;

2. A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers;

3. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized*[;]***. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans "K" and "L";**

4. A description of coverage for emergency and urgently needed care and other out-of-service area coverage;

5. A description of limitations on referrals to restricted network providers and to other providers;

6. A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer; and

7. A description of the Medicare Select issuer's quality assurance program and grievance procedure.

(M)

1. At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

2. For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, *[coverage for prescription drugs,]* coverage for at-home recovery services or coverage for Part B excess charges.

(N) Medicare Select policies and certificates shall provide for continuation of coverage in the event the secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

1. Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the

opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

2. For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, *[coverage for prescription drugs,]* coverage for at-home recovery services or coverage for Part B excess charges.

(9) Open Enrollment.

(A) No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6)-month period beginning with the first day of the first month in which the applicant is both sixty-five (65) years of age or older and is enrolled for benefits under Medicare Part B.

1. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

(E) No issuer required by subsection (B) of this section to issue policies or certificates of Medicare supplement insurance shall discriminate as to rates, between the rates charged to persons enrolled under subsection (B) of this section and the average rates charged for participation in that policy form number or certificate form number by persons enrolled in Medicare Part B by reason of age, or discriminate between persons entitled to enroll in the policy form number or certificate form number under subsection (B) of this section and other enrollees in the policy form number or certificate form number in other terms or conditions of the plan, policy form number, or certificate form number.

1. An issuer must demonstrate compliance with this section for each plan, type, and form level permitted under subsection (13)*[(C)]***(D)** by either—

A. Charging a premium rate for disabled persons that does not exceed the lowest available aged premium rate for that plan, type, and form level; or

B. Charging a premium rate for disabled persons that does not exceed the "weighted average aged premium rate" for that plan, type, and form level, and providing, at the time of each rate filing, its calculation of the "weighted average aged premium rate" for each plan, type, and form level.

2. The "weighted average aged premium rate" is determined by—

A. First multiplying the premium rate (calculated prior to modal, area, and other factors) for each age band, age sixty-five (65) and over, by the number of Missouri insureds in-force in that age band to arrive at the total Missouri premium for each age band age sixty-five (65) and over; and

B. Then calculating the sum of the Missouri premium for all age bands age sixty-five (65) and over to arrive at the total Missouri premium for all age bands age sixty-five (65) and over; and

C. Then calculating the sum of the Missouri insureds*[-]*in-force for all age bands age sixty-five (65) and over to arrive at the total number of Missouri insureds in-force for all age bands age sixty-five (65) and over; and

D. Then dividing the total Missouri premium for all age bands age sixty-five (65) and over by the total number of Missouri insureds in-force for all age bands, age sixty-five (65) and over to determine the weighted average aged premium rate.

3. Modal, area, and other factors may be added to the disabled premium.

(H) No Medicare supplement carrier shall, directly or indirectly enter into any contract, agreement or arrangement with an *[agent or broker]* **insurance producer** that provides for or results in the compensation paid to an *[agent or broker]* **insurance producer** for the sale of a Medicare supplement policy or certificate to be varied because of the age, health status, claims experience, receipt of health care or medical condition of an applicant eligible by reason of subsection (B) of this section for Medicare supplement insurance.

(I) A Medicare supplement carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an *[agent or broker]* **insurance producer**, if any, for the sale, during the open enrollment periods described in subsection (B) of this section, of a Medicare supplement insurance policy or certificate.

(J) No Medicare supplement insurance carrier shall terminate, fail to renew or limit its contract or agreement of representation with an *[agent or broker]* **insurance producer** for any reason related to the age, health status, claims experience, receipt of health care or medical condition of an applicant, eligible by reason of subsection (B) of this section for Medicare supplement insurance, placed by the *[agent or broker]* **insurance producer** with the Medicare supplement insurance carrier.

(10) Guaranteed Issue for Eligible Persons.

(A) Guaranteed Issue.

1. Eligible persons are those individuals described in subsection (B) of this section who *[apply to enroll under the policy not later than sixty-three (63) days after the date of the termination of enrollment described in subsection (B) of this section,]* **seek to enroll under the policy during the period specified in subsection (C) of this section,** and who submit evidence*[, acceptable to the director,]* of the date of termination *[or disenrollment]***, disenrollment, or Medicare Part D enrollment** with the application for a Medicare supplement policy.

2. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection *[(C)]***(E)** of this section that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(B) Eligible Persons. An eligible person is an individual described in any of the following paragraphs:

1. The individual is enrolled under an employee welfare benefit plan **that provides health benefits that supplement the benefits under Medicare**; and the plan terminates, or the plan ceases to provide *[substantial health benefits to the individual either because the plan is modified or amended, or because the plan terminates, or because the individual leaves the plan]* **all such supplemental health benefits to the individual**;

2. The individual is enrolled with a Medicare*[+Choice]* **Advantage** organization under a Medicare*[+Choice]***Advantage** plan under Part C of Medicare, and any of the following circumstances apply, **or the individual is sixty-five (65) years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:**

A. The organization's or plan's certification has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

B. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or because the plan is terminated for all individuals within a residence area or because of another change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856);

C. The individual demonstrates, in accordance with guidelines established by the secretary, that—

(I) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(II) The organization, *[or agent]* **insurance producer**, or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

D. The individual meets such other exceptional conditions as the secretary may provide;

3.

A. The individual is enrolled with—

(I) An eligible organization under a contract under section 1876 (Medicare risk or cost);

(II) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(III) An organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan); or

(IV) An organization under a Medicare Select Policy; and

B. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (10)(B)2.;

4. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because—

A.

(I) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(II) Of other involuntary termination of coverage or enrollment under the policy;

B. The issuer of the policy substantially violated a material provision of the policy; or

C. The issuer, *[or an agent]* **insurance producer,** or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

5.

A. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare*[+Choice]***Advantage** organization under a Medicare*[+Choice]***Advantage** plan under Part C of Medicare, any eligible organization under a contract under section 1876 (Medicare risk or cost), any similar organization operating under demonstration project authority, **any PACE provider under section 1894 of the Social Security Act,** an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan), or a Medicare Select policy; and

B. The subsequent enrollment under subparagraph (10)(B)5.A. is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or

6. The individual, upon first becoming eligible for benefits under Part A of Medicare *[and enrolling in Medicare Part B]*, enrolls in a Medicare*[+Choice]***Advantage** plan under Part C of Medicare, **or with a PACE provider under section 1894 of the Social Security Act,** and disenrolls from the plan **or program** by not later than twelve (12) months after the effective date of enrollment; and

7. The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in paragraph (E)4. of this section; and

*[7.]***8.** Any individual who terminates Medicare supplement coverage within thirty (30) days of the annual policy anniversary.

(C) Guarantee Issue Time Periods.

1. In the case of an individual described in paragraph (B)1. of this section, the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

2. In the case of an individual described in paragraph (B)2., (B)3., (B)5. or (B)6. of this section whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage was terminated;

3. In the case of an individual described in subparagraph (B)4.A., of this section the guarantee issue period begins on the earlier of: (i) the date that individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage was terminated;

4. In the case of an individual described in paragraph (B)2., subparagraph (B)4.B., (B)4.C., paragraph (B)5. or (B)6., of this section who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;

5. In the case of an individual described in paragraph (B)7. of this section, the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty (60)-day period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

6. In the case of an individual described in subsection (B) of this section but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment or the effective date of the loss of coverage under the group health plan and ends on the date that is sixty-three (63) days after the effective date.

(D) Extended Medigap Access for Interrupted Trial Periods.

1. In the case of an individual described in paragraph (B)5. of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in subparagraph (B)5.A. of this section is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (10)(B)6.; and

2. In the case of an individual described in paragraph (B)6. of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program

described in paragraph (B)6. of this section is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (10)(B)6.; and

3. For purposes of paragraphs (B)5. and (B)6. of this section, no enrollment of an individual with an organization or provider described in subparagraph (B)5.A. of this section, or with a plan or in a program described in paragraph (B)6. of this section, may be deemed to be an initial enrollment under this paragraph after the two (2)-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

*[(C)]***(E)** Products to Which Eligible Persons Are Entitled. The Medicare supplement policy to which eligible persons are entitled under—

1. Paragraphs (10)(B)1., 2., 3. and 4. is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F **(including F with a high deductible), K or L** offered by any issuer;

[2. Paragraph (10)(B)5. is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in paragraph (C)1. of this section;]

A. Subject to subparagraph B, paragraph (10)(B)5. is the same Medicare supplement policy in which the individual was most recently enrolled, if available from the same issuer, or, if not so available, a policy described in paragraph 1. of this subsection;

B. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this subparagraph is:

(I) The policy available from the same issuer but modified to remove the outpatient prescription drug coverage; or

(II) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer;

*[3.]***2.** Paragraph(10)(B)6. shall include any Medicare supplement policy offered by any issuer; *[and]*

3. Paragraph (10)(B)7. is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage; and

4. Paragraph (10)(B)*[7.]***8.** shall include any Medicare supplement policy offered by any issuer but only a policy of the same plan as the coverage in which the individual was most recently enrolled.

*[(D)]***(F)** Notification Provisions.

1. At the time of an event described in subsection (B) of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (A). Such notice shall be communicated contemporaneously with the notification of termination.

2. At the time of an event described in subsection (B) of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (A) of this section. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.

(12) Loss Ratio Standards and Refund or Credit of Premium.

(A) Loss Ratio Standards.

1.

A. A Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form the higher of the originally filed anticipated loss ratio or—

(I) At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

(II) At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies.

B. The ratios specified in this subsection shall be calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. **Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:**

(I) Home office and overhead costs;

(II) Advertising costs;

(III) Commissions and other acquisition costs;

(IV) Taxes;

(V) Capital costs;

(VI) Administrative costs; and

(VII) Claims processing costs.

2. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards (future loss ratio).

3. For purposes of applying paragraph (A)1. of this section and paragraph *[(C)]***(D)**3. of section (13) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

4. For policies issued prior to July 30, 1992, expected claims in relation to premiums shall meet—

A. The originally filed anticipated loss ratio when combined with the actual experience since inception (the lifetime loss ratio);

B. The appropriate loss ratio requirement from parts (A)1.A.(I) and (II) of this section when combined with actual experience beginning with *[either April 28, 1996, or January 1, 1996]* **January 1, 2006** to date; and

C. The appropriate loss ratio requirement from parts (A)1.A.(I) and (II) of this section over the entire future period for which the rates are computed to provide coverage.

(B) Refund or Credit Calculation.

1. An issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

2. If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For

purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

3. For the purposes of this section, policies or certificates issued prior to July 30, 1992, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after *[April 28, 1996]* **January 1, 2006**. The first report shall be due by May 31, *[1998]* **2008**.

4. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a *de minimis* level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen (13)-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(13) Filing and Approval of Policies and Certificates and Premium Rates.

(B) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the director in the state in which the policy or certificate was issued.

*[(B)]***(C)** An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the director in accordance with the filing requirements and procedures prescribed by the director.

*[(C)]***(D)**

1. Except as provided in paragraph 2. of this subsection, an issuer shall not file for approval more than one (1) form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

2. An issuer may offer, with the approval of the director, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one (1) for each of the following cases:

A. The inclusion of new or innovative benefits;

B. The addition of either direct response or *[agent]* **insurance producer** marketing methods;

C. The addition of either guaranteed issue or underwritten coverage; and

D. The offering of coverage to individuals eligible for Medicare by reason of disability.

3. For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

*[(D)]***(E)**

1. Except as provided in subparagraph 1.A. of this subsection, an issuer shall continue to make available for purchase any policy form or certificate form issued after April 8, 1993, that has been approved by the director. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

A. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the director in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the director, the issuer shall no longer offer for sale the policy form or certificate form in this state.

B. An issuer that discontinues the availability of a policy form or certificate form pursuant to subparagraph 1.A. of this subsection shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate.

2. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

3. Effect of change in rating structure or methodology.

A. A change in the rating structure or methodology includes, but is not limited to:

(I) A change between community rating, issue-age rating, and attained-age rating;

(II) A change in class structure (e.g., one class v. smoker/non-smoker class, unisex v. male/female classes); and

(III) A change between rating for each age v. age-banded rates.

B. A change in the rating structure or methodology shall be considered a discontinuance under paragraph 1. of this subsection unless the issuer complies with the following requirements:

(I) The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates; and

(II) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. Such actuarially equivalent policies or certificates shall be combined for filing purposes under paragraph (13)*[(G)]***(H)**11. The director may approve a change to the differential which is in the public interest.

C. Notwithstanding subparagraph B. of this paragraph, where an issuer changes a rating structure or methodology and rates calculated under the new methodology are not actuarially equivalent to the old rates, the change in rating structure or methodology will be considered a discontinuance under subparagraph (13)*[(D)]***(E)**1.A. The actuarial equivalency of rates must be determined by a comparison of weighted average premium rate under the old and the new methodology, except in the case of a change between attained-age and issue-age rating where the actuarial equivalency of the rates will be determined from a comparison of actuarial present value of lifetime premiums by age or age-band.

*[(E)]***(F)**

1. Except as provided in paragraph *[(E)]***(F)**2. of this section, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in section (12) of this rule.

2. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

*[(F)]***(G)**

1. An issuer shall not present for filing or approval a rate structure for its Medicare supplement policies or certificates issued after January 1, 2000, based upon attained-age rating as a structure or methodology. Notwithstanding, an issuer may continue in-force policies and certificates issued prior to January 1, 2000.

2. Where an issuer files for approval of a rate structure for policy forms or certificate forms which reflects a change in methodology from attained age to issue age, the issuer must demonstrate the actuarial equivalency of the rates proposed with the previously approved attained-age rates as required by paragraph (13)*[(D)]***(E)**3. If the policy forms or certificate forms were at any time approved by the director under an issue age methodology, the issuer must use the most recently approved issue age rate schedule as its proposed rate schedule for the policy forms or certificate forms and need make no further showing of actuarial equivalency under (13)*[(D)]***(E)**3.

*[(G)]***(H)** Filing requirements and procedures for change of Medicare supplement insurance premium rate and for annual filing of

premium rates.

1. When an issuer files for approval of annual premium rates for a plan under subsection (12)(C) or a change of premium rates for a plan under subsection (13)*[(B)]***(C)**, the following documentation must be provided to the director as part of the rate filing in addition to any other documentation required by law or regulation:

A. A completed Medicare Supplement Rate Filing Document (Missouri Form 375-0065, revised 10/98), which *[is incorporated herein by reference]* **can be accessed at the department's website at www.insurance.mo.gov**;

B. An actuarial memorandum supporting the rating schedule;

C. A report of durational experience (for standardized Medicare supplement plans only);

D. A projection correctly derived from reasonable assumptions;

E. A clear statement of all of the assumptions used to prepare the rate filing, including the source of trend;

F. All formulas used to prepare the projection except for formulas which can be ascertained from a cursory inspection of the projection itself; and

G. The issuer's current rate schedule and the proposed rate schedule for this state, including rates for disabled persons, if any, and all rating factors, including, but not limited to: area; smoker/non-smoker; standard/substandard.

2. The report of durational experience must contain for each calendar year of issue the following data by duration: incurred claims and earned premium; resultant loss ratio; and life-years. The durational split may be either by policy or certificate duration, calendar duration or calendar year of experience within each calendar year of issue.

3. The projection must—

A. State the incurred claims and earned premium, resultant loss ratio and corresponding life-years for each of the preceding calendar years beginning with the year in which the policy or certificate was first issued and must include the total for each category (incurred claims and earned premium, resultant loss ratio, and corresponding life-years) for all preceding calendar years;

B. State the projected incurred claims and projected earned premium, resultant loss ratios and corresponding life-years for at least each of the ten (10) calendar years subsequent to the rate filing and must include the total for each category (projected incurred claims and projected earned premium, resultant loss ratio, and corresponding life-years) for all projected calendar years;

C. Include a calculation of the sums of the combined total figures reported under subparagraph A. of this paragraph and those reported under subparagraph B. of this paragraph; and

D. Include, for pre-standardized Medicare supplement plans, the respective totals of the incurred claims and earned premium, resultant loss ratio, and corresponding life-years for the period beginning April 28, 1996, or alternatively, January 1, 1996, through the end of the projection period described in subparagraph B. of this paragraph.

4. Where assumptions include interest, the totals for incurred claims accumulated/discounted with interest, earned premium accumulated/discounted with interest, and the resultant loss ratio must also be shown in all parts of the projection described in paragraph *[(G)]***(H)**3. of this section.

5. Both the report of durational experience and the projection must report Missouri and national data with respect to incurred claims, earned premium, loss ratio, and life-years. The projection must also report this information both with and without the rate change requested.

6. The issuer must specify whether the figures reported as incurred claims were determined by adding claims paid to unpaid claims reserves or by the actual runoff of claims. The method of determining the incurred claims must be consistent throughout the filing and supporting documentation.

7. Changes in active life reserves or claims expenses may not be included in incurred claims in the rate filing or any supplemental documentation.

8. For purposes of this section, "incurred claims" means the dollar amount of incurred claims.

9. Earned premium reported in the rate filing or any supporting documentation must include modal loadings and policy fees. An adjustment for premium refunds, if any, must also be made to earned premium and the details of the adjustment must be provided to the director with the filing. Changes in active life reserves may not be included in earned premium.

10. Life-years reported in a rate filing or supplemental documentation must be calculated in the same manner as for refund calculations.

11. Rate filings for each plan, type, and form level permitted under subsection (13)*[(C)]***(D)** for standardized Medicare supplement plans marketed after June 30, 1998, must demonstrate compliance with the requirements of subsection (9)(E). The "weighted average aged premium," must be recalculated for each filing using current data, unless the issuer demonstrates compliance under subparagraph (9)(E)1.A. The figure used in the calculation for the total number of insureds in-force for all age bands, age sixty-five (65) and over, must be the same as the figure reported on Missouri Form 375-0065 for the "Number of Missouri Aged Insureds."

12. For standardized Medicare supplement plans, the Medicare Supplement Rate Filing Document, the report of durational experience, and the projection must be provided separately for each plan, type, and form level permitted under subsection (13)*[(C)]***(D)**.

13. For pre-standardized Medicare supplement rate plans, the information contained in the Medicare Supplement Rate Filing Document and projection may be pooled within a type.

14. The rates, rating schedule and supporting documentation required to be filed under subsection *[(G)]***(H)** of this section as part of a rate filing and all supplementary documentation in connection with the rate filing must be accompanied by the certification of a qualified actuary that to the best of the actuary's knowledge and judgment, the following items are true with respect to the documentation submitted:

A. The assumptions present the actuary's best judgment as to the expected value for each assumption and are consistent with the issuer's business plan at the time of the filing;

B. The anticipated lifetime, future, and third-year loss ratios for the policy form or certificate form for which the rates are filed comply with the loss ratio requirements of subsection (12)(A) for policy forms or certificate forms of its type delivered or issued for delivery in this state;

C. With respect to rate filings concerning pre-standardized plans, the loss ratio for year 1996 (from April 28 or from January 1) through the end of the projection period complies with the loss ratio requirements of subsection (12)(A) for policies or certificates issued prior to July 30, 1992, and delivered or issued for delivery in this state;

D. Where the rate filing concerns a policy or certificate as to which rating methodologies have changed or are presented for approval based on a change in methodology, the percentage differential between the discontinued and subsequent (or new) rates has not changed;

E. All components of the filing, including rates, rating schedules, and supporting documentation, were prepared based on the current standards of practice promulgated by the Actuarial Standards Board;

F. The rate filing, including rates, rating schedule, and supporting documentation, is in compliance with the applicable laws and regulations of this state; and

G. The rates requested are reasonable in relationship to the benefits provided by the policy or certificate.

(14) Permitted Compensation Arrangements.

(A) An issuer or other entity may provide commission or other compensation to an *[agent]* **insurance producer** or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(C) No issuer or other entity shall provide compensation to its *[agents or other producers]* **insurance producers** and no *[agent or]* producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

(15) Required Disclosure Provisions.

(A) General Rules.

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

2. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

3. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

4. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

5. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

6.

A. Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the *[Health Care Financing Administration]* **Centers for Medicare and Medicaid Services (CMS)** and in a type size no smaller than twelve (12)-point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this rule. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

B. For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

(C) MMA Notice Requirements. Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

*[(C)]***(D)** Outline of Coverage Requirements for Medicare Supplement Policies.

1. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant.

2. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than twelve (12)-point type, immediately above the company name: **"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."**

3. The outline of coverage provided to applicants pursuant to this section consists of four (4) parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12)-point type. All plans A–*[J]***L** shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

4. The following items shall be included in the outline of coverage in the order prescribed below.

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page: ***1 of 2***

Benefit Plans _____ [insert letters of plans being offered

[Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans.] [These] ***This*** chart*[s]* show*[s]* the benefits included in each ***of the standard Medicare supplement*** plans. Every company must make available Plan "A." Some plans may not be available in your state.

See Outlines of Coverage sections for details about ALL plans

Basic Benefits *[Included in All Plans]* ***for Plans A - J:***
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or*[, in the case of hospital outpatient department services under a prospective payment system, applicable]* copayments ***for hospital outpatient services.***
Blood: First three pints of blood each year.

A	B	C	D	E	F F*	G	H	I	J J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing ***Facility*** Co*[-]*insurance	Skilled Nursing ***Facility*** Co*[-]*insurance	Skilled Nursing ***Facility*** Co*[-]*insurance	Skilled Nursing ***Facility*** Co*[-]*insurance	Skilled Nursing ***Facility*** Co*[-]*insurance	Skilled Nursing ***Facility*** Co*[-]*insurance	Skilled Nursing ***Facility*** Co*[-]*insurance	Skilled Nursing ***Facility*** Co*[-]*insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							[Basic Drugs ($1250 Limit)]	*[Basic Drugs ($1250 Limit)]*	*[Extended Drugs ($3000 Limit)]*
				Preventive Care ***NOT covered by Medicare***					Preventive Care ***NOT covered by Medicare***

*** Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same** *[or offer the same]* **benefits as Plans F and J after one has paid a calendar year [$1690] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do***[es]* **not include***[, in plan J]* **the plan's separate** *[prescription drug deductible or, in plans F and J, the plan's]* **foreign travel emergency deductible.**

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page 2

Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J	*K***	*L***
Basic Benefits	*100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End* *50% Hospice cost-sharing* *50% of Medicare-eligible expenses for the first three pints of blood* *50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services*	*100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End* *75% Hospice cost-sharing* *75% of Medicare-eligible expenses for the first three pints of blood* *75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services*
Skilled Nursing Coinsurance	*50% Skilled Nursing Facility Coinsurance*	*75% Skilled Nursing Facility Coinsurance*
Part A Deductible	*50% Part A Deductible*	*75% Part A Deductible*
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	*$[4000] Out of Pocket Annual Limit****	*$[2000] Out of Pocket Annual Limit****

*** Plans K and L provide for different cost-sharing for items and services than Plans A – J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.*

****The out-of-pocket annual limit will increase each year for inflation.*

See Outlines of Coverage for details and exceptions.

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for ***insurance producers***:]
Neither [insert company's name] nor its ***insurance producers*** are connected with Medicare.

[for direct response:]
[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this rule. An issuer may use additional benefit plan designations on these charts pursuant to Section (7)(D) of this rule.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Director.]

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $*[[764]]* ***[876]***	$0	$*[[764]]* ***[876]***(Part A deductible)
61st thru 90th day	All but $*[[191]]* ***[219]*** a day	$*[[191]]* ***[219]*** a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $*[[382]]* ***[438]*** a day	$*[[382]]* ***[438]*** a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility			
Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $*[[95.50]]* ***[109.50]*** a day	$0	Up to $*[[95.50]]* ***[109.50]*** a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

***** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

PLAN A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $*[*100*]* of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $*[*100*]* of Medicare Approved Amounts*	$0	$0	$ *[*100*]* (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
[Part B Excess Charges (Above Medicare Approved Amounts)]	*[$0]*	*[$0]*	*[All costs]*
Part B Excess Charges (Above Medicare Approved Amounts)	***$0***	***$0***	***All costs***
BLOOD			
First 3 pints	$0	All costs	$0
Next $*[*100*]* of Medicare Approved Amounts*	$0	$0	$ *[*100*]* (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—*[BLOOD]*TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $*[*100*]* of Medicare Approved Amounts*	$0	$0	$*[*100*]* (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $*[[764]]* ***[876]***	$*[[764]]* ***[876]***(Part A deductible)	$0
61st thru 90th day	All but $*[[191]]* ***[219]*** a day	$*[[191]]* ***[219]*** a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $*[[382]]* ***[438]*** a day	$*[[382]]* ***[438]*** a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $*[[95.50]]* ***[109.50]*** a day	$0	Up to $*[[95.50]]* ***[109.50]*** a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

***** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

PLAN B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $*[*100*]* of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $*[*100*]* of Medicare Approved Amounts*	$0	$0	$*[*100*]* (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
[Part B Excess Charges (Above Medicare Approved Amounts)]	*[$0]*	*[$0]*	*[All costs]*
Part B Excess Charges (Above Medicare Approved Amounts)	***$0***	***$0***	***All costs***
BLOOD			
First 3 pints	$0	All costs	$0
Next $*[*100*]* of Medicare Approved Amounts*	$0	$0	$*[*100*]* (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—*[BLOOD]* TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $*[*100*]* of Medicare Approved Amounts*	$0	$0	$*[*100*]* (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $*[[764]]* ***[876]***	$*[[764]]* ***[876]***(Part A deductible)	$0
61st thru 90th day	All but $*[[191]]* ***[219]*** a day	$*[[191]]* ***[219]*** a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $*[[382]]* ***[438]*** a day	$*[[382]]* ***[438]*** a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $*[[95.50]]* ***[109.50]*** a day	Up to $*[[95.50]]* ***[109.50]*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

***** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

PLAN C

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $*[*100*]* of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $*[*100*]* of Medicare Approved Amounts*	$0	$*[*100*]* (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
[Part B Excess Charges (Above Medicare Approved Amounts)]	*[$0]*	*[$0]*	*[All costs]*
Part B Excess Charges (Above Medicare Approved Amounts)	***$0***	***$0***	***All costs***
BLOOD			
First 3 pints	$0	All costs	$0
Next $*[*100*]* of Medicare Approved Amounts*	$0	$*[*100*]* (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—*[BLOOD]* TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $*[*100*]* of Medicare Approved Amounts*	$0	$*[*100*]* (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
OTHER BENEFITS—NOT COVERED BY MEDICARE			
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $*[[764]]* ***[876]***	$*[[764]]* ***[876]*** (Part A deductible)	$0
61st thru 90th day	All but $*[[191]]* ***[219]*** a day	$*[[191]]* ***[219]*** a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $*[[382]]* ***[438]*** a day	$*[[382]]* ***[438]*** a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $*[[95.50]]* ***[109.50]*** a day	Up to $*[[95.50]]* ***[109.50]*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

***** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $*[*100*]* of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $*[*100*]* of Medicare Approved Amounts*	$0	$0	$*[*100*]* (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
[Part B Excess Charges (Above Medicare Approved Amounts)]	*[$0]*	*[$0]*	*[All costs]*
Part B Excess Charges (Above Medicare Approved Amounts)	***$0***	***$0***	***All costs***
BLOOD			
First 3 pints	$0	All costs	$0
Next $*[*100*]* of Medicare Approved Amounts*	$0	$0	$*[*100*]* (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—*[BLOOD]* TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $*[100]* of Medicare Approved Amounts*	$0	$0	$*[100]* (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual charges to $40 a visit	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN E

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $*[[764]]* ***[876]***	$*[[764]]* ***[876]*** (Part A deductible)	$0
61st thru 90th day	All but $*[[191]]* ***[219]*** a day	$*[[191]]* ***[219]*** a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $*[[382]]* ***[438]*** a day	$*[[382]]* ***[438]*** a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $*[[95.50]]* ***[109.50]*** a day	Up to $*[[95.50]]* ***[109.50]*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

***** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

PLAN E

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $*[*100*]* of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $*[*100*]* of Medicare Approved Amounts*	$0	$0	$*[*100*]* (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
[Part B Excess Charges (Above Medicare Approved Amounts)]	*[$0]*	*[$0]*	*[All costs]*
Part B Excess Charges (Above Medicare Approved Amounts)	***$0***	***$0***	***All costs***
BLOOD			
First 3 pints	$0	All costs	$0
Next $*[*100*]* of Medicare Approved Amounts*	$0	$0	$*[*100*]* (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—*[BLOOD]* TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $*[*100*]* of Medicare Approved Amounts*	$0	$0	$*[*100*]* (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued)

PLAN E

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services *[such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education,]* administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same** *[or offers the same]* **benefits as Plan F after one has paid a calendar year** *[[$1500]]* ***[$1690] **deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are** *[[$1500]]* ***[$1690]*****. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]***

SERVICES	MEDICARE PAYS	*[AFTER YOU PAY $[[1500]] [1690] DEDUCTIBLE,**] PLAN PAYS*	*[IN ADDITION TO $[[1500]] [1690] DEDUCTIBLE,**] YOU PAY*
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $*[[764]] **[876]***	$*[[764]] **[876]*** (Part A	$0
61st thru 90th day	All but $*[[191]] **[219]*** a day	deductible) $*[[191]] **[219]*** a day	$0
91st day and after:			
While using 60 Lifetime reserve days	All but $*[[382]] **[438]*** a day	$*[[382]] **[438]*** a day	$0
Once lifetime reserve days Are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $*[[95.50]] **[109.50]*** a day	Up to $*[[95.50]] **[109.50]*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

(continued)

****** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

Once you have been billed $[*100*]* of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same** *[or offers the same]* **benefits as Plan F after one has paid a calendar year** *[[$1500]]* ***[$1690]*** **deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are** *[[$1500]]* ***[$1690]*****. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.***]***

SERVICES	MEDICARE PAYS	*[*AFTER YOU PAY *$[[1500]] [1690]* DEDUCTIBLE,*****]* PLAN PAYS	*[*IN ADDITION TO *$[[1500]] [1690]* DEDUCTIBLE,*****]* YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, Such as physician's Services, inpatient and Outpatient medical and Surgical services and Supplies, physical and Speech therapy, Diagnostic tests, Durable medical Equipment,			
First $*[*100*]* of Medicare Approved amounts*	$0	$*[*100*]* (Part B deductible)	$0
Remainder of Medicare Approved amounts	Generally 80%	Generally 20%	$0
[Part B excess charges (Above Medicare approved amounts)]	*[$0]*	*[100%]*	*[$0]*
Part B excess charges (Above Medicare Approved Amounts)	***$0***	***100%***	***$0***
BLOOD			
First 3 pints	$0	All costs	$0
Next $*[*100*]* of Medicare Approved amounts*	$0	$*[*100*]* (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—*[BLOOD]* TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	*MEDICARE PAYS*	*[AFTER YOU PAY $[1690] DEDUCTIBLE,** PLAN PAYS]*	*[IN ADDITION TO $[1690] DEDUCTIBLE,** YOU PAY]*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $*[100]* of Medicare approved Amounts*	$0	$*[100]* (Part B deductible)	$0
Remainder of Medicare approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	*[AFTER YOU PAY $[[1500]] [1690] DEDUCTIBLE,**]* PLAN PAYS	*[IN ADDITION TO $[[1500]] [1690] DEDUCTIBLE,**]* YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary Emergency care services Beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $*[[764]]* ***[876]***	$*[[764]]* ***[876]*** (Part A deductible)	$0
61st thru 90th day	All but $*[[191]]* ***[219]*** a day	$*[[191]]* ***[219]*** a day	$0
91st day and after:			
—While using 60 lifetime reserve days			$0
—Once lifetime reserve days are used:	All but $*[[382]]* ***[438]*** a day	$*[[382]]* ***[438]*** a day	
—Additional 365 days		100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
	$0		
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $*[[95.50]]* **[109.50]** a day	Up to $*[[95.50]]* ***[109.50]*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

***** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN G

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $*[*100*]* of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $*[*100*]* of Medicare Approved Amounts*	$0	$0	$*[*100*]* (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
[Part B Excess Charges (Above Medicare Approved Amounts)]	*[$0]*	*[80%]*	*[20%]*
Part B Excess Charges (Above Medicare Approved Amounts)	***$0***	***80%***	***20%***
BLOOD			
First 3 pints	$0	All costs	$0
Next $*[*100*]* of Medicare Approved Amounts*	$0	$0	$*[*100*]* (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—*[BLOOD]* TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $*[100]* of Medicare Approved Amounts*	$0	$0	$*[100]* (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual charges to $40 a visit	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN H

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $*[[764]]* ***[876]***	$*[[764]]* ***[876]*** (Part A deductible)	$0
61st thru 90th day	All but $*[[191]]* ***[219]*** a day	$*[[191]]* ***[219]*** a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $*[[382]]* ***[438]*** a day	$*[[382]]* ***[438]*** a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days		100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
	$0		
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $*[[95.50]]* ***[109.50]*** a day	Up to $*[[95.50]]* ***[109.50]*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

***** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

PLAN H

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $*[100]* of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $*[100]* of Medicare Approved Amounts*	$0	$0	$*[100]* (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
[Part B Excess Charges (Above Medicare Approved Amounts)]	*[$0]*	*[$0]*	*[All Costs]*
Part B Excess Charges (Above Medicare Approved Amounts)	***$0***	***0%***	***All Costs***
BLOOD			
First 3 pints	$0	All costs	$0
Next $*[100]* of Medicare Approved Amounts*	$0	$0	$*[100]* (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—*[BLOOD]* TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $*[100]* of Medicare Approved Amounts*	$0	$0	$*[100]* (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued)

PLAN H

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum
[BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE] *[First $250 each calendar year]* *[Next $2,50 each calendar year]* *[Over $2,500 each calendar year]*	 *[$0]* *[$0]* *[$0]*	 *[$0]* *[50%--$1,250 calendar year maximum benefit]* *[$0]*	 *[$250]* *[50%]* *[All costs]*

PLAN I

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $*[[764]]* ***[876]***	$*[[764]]* ***[876]*** (Part A deductible)	$0
61st thru 90th day	All but $*[[191]]* ***[219]*** a day	$*[[191]]* ***[219]*** a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $*[[382]]* ***[438]*** a day	$*[[382]]* ***[438]*** a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $*[[95.50]]* ***[109.50]*** a day	Up to $*[[95.50]]* ***[109.50]*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

***** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

PLAN I

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $*[*100*]* of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $*[*100*]* of Medicare Approved Amounts*	$0	$0	$*[*100*]* (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
[Part B Excess Charges (Above Medicare Approved Amounts)]	*[$0]*	*[100%]*	*[$0]*
Part B Excess Charges (Above Medicare Approved Amounts)	***$0***	***100%***	***$0***
BLOOD			
First 3 pints	$0	All costs	$0
Next $*[*100*]* of Medicare Approved Amounts*	$0	$0	$*[*100*]* (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—*[BLOOD]* TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN I

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $*[*100*]* of Medicare Approved Amounts*	$0	$0	$*[*100*]* (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan —Benefit for each visit	$0	Actual charges to $40 a visit	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
[BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE]			
[First $250 each calendar year]	*[$0]*	*[$0]*	*[$250]*
[Next $2,50 each calendar year]	*[$0]*	*[50%--$1,250 calendar year maximum benefit]*	*[50%]*
[Over $2,500 each calendar year]	*[$0]*	*[$0]*	*[All costs]*

PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[* **This high deductible plan pays the same** *[or offers the same]* **benefits as Plan J after one has paid a calendar year** ***[[$1500]] [$1690]*** **deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are** ***[[$1500]] [$1690].*** **Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's** *[separate prescription drug deductible or the plan's]* **separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	*[*AFTER YOU PAY *$[[1500]] [1690]* DEDUCTIBLE,*** *]* PLAN PAYS	*[*IN ADDITION TO *$[[1500]] [1690]* DEDUCTIBLE,*** *]* YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but *$[[764]] **[876]***	*$[[764]] **[876]*** (Part A deductible)	$0
61st thru 90th day	All but *$[[191]] **[219]*** a day	*$[[191]] **[219]*** a day	$0
91st day and after:			
—While using 60 lifetime reserve days			$0
—Once lifetime reserve days are used:	All but *$[[382]] **[438]*** a day	*$[[382]] **[438]*** a day	
—Additional 365 days			$0***
—Beyond the additional 365 days	$0	100% of Medicare eligible expenses	
	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but *$[[95.50]] **[109.50]*** a day	Up to *$[[95.50]] **[109.50]*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $*[*100*]* of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same** *[or offers the same]* **benefits as Plan J after one has paid a calendar year** *[[$1500]]* ***[$1690]*** **deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are** *[[$1500]]* ***[$1690]*****. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's** *[separate prescription drug deductible or the plan's]* **separate foreign travel emergency deductible.*****]***

SERVICES	MEDICARE PAYS	*[*AFTER YOU PAY $*[[1500]]* ***[1690]*** DEDUCTIBLE,***]* PLAN PAYS	*[*IN ADDITION TO $*[[1500]]* ***[1690]*** DEDUCTIBLE,***]* YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $*[*100*]* of Medicare Approved Amounts*	$0	$*[*100*]* (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
[Part B Excess Charges (Above Medicare Approved Amounts)]	*[$0]*	*[100%]*	*[$0]*
Part B Excess Charges (Above Medicare Approved Amounts)	***$0***	***100%***	***$0***
BLOOD			
First 3 pints	$0	All Costs	$0
Next $*[*100*]* of Medicare Approved Amounts*	$0	$*[*100*]* (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—*[BLOOD]* TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN J or HIGH DEDUCTIBLE PLAN J

PARTS A & B

SERVICES	*MEDICARE PAYS*	*[AFTER YOU PAY $ [1690] DEDUCTIBLE,**] PLAN PAYS*	*[IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First $*[100]* of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $*[100]* (Part B deductible) 20%	$0 $0 $0
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan —Benefit for each visit —Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit) —Calendar year maximum	 $0 $0 $0	 Actual charges to $40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week $1,600	 Balance

(continued)

PLAN J or HIGH DEDUCTIBLE PLAN J

PARTS A & B

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	*MEDICARE PAYS*	*[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS*	*[IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY*
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum
[EXTENDED OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE] *[First $250 each calendar year]* *[Next $6,000 each calendar year]* *[Over $6,000 each calendar year]*	 *[$0]* *[$0]* *[$0]*	 *[$0]* *[50%--$3,000 calendar year maximum benefit]* *[$0]*	 *[$250]* *[50%]* *[All costs]*
***PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services *[such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education.]* administered or ordered by your doctor when not covered by Medicare First $120 each calendar year Additional charges	 $0 $0	 $120 $0	 $0 All costs

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN K

** You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.*

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[438](50% of Part A deductible)	$[438](50% of Part A deductible)♦
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility			
Within 30 days after leaving the hospital	All approved amounts	$0	$0
First 20 days	All but $[109.50] a day	Up to $[54.75] a day	Up to $[54.75] a day ♦
21st thru 100th day		$0	All costs
101st day and after	$0		
BLOOD			
First 3 pints	$0	50%	50%♦
Additional amounts	100%	$0	$0

HOSPICE CARE *Available as long as your doctor certifies you are terminally ill and you elect to receive these services*	*Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care*	*50% of coinsurance or copayments*	*50% of coinsurance or copayments♦*

(continued)

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN K

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**** Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare Approved Amounts****	$0	$0	$[100] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$4000])*
BLOOD			
First 3 pints	$0	50%	50%♦
Next $[100] of Medicare Approved Amounts****	$0	$0	$[100] (Part B deductible)**** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[4000] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K

PARTS A & B

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY**
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	*100%*	*$0*	*$0*
*—Durable medical equipment First $[100] of Medicare Approved Amounts*******	*$0*	*$0*	*$[100] (Part B deductible) ♦*
Remainder of Medicare Approved Amounts	*80%*	*10%*	*10%♦*

*******Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.*

PLAN L

**** You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[2000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.***

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

***** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.***

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY**
*HOSPITALIZATION***			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	*All but $[876]*	*$[657] (75% of Part A deductible)*	*$[219] (25% of Part A deductible)♦*
61st thru 90th day	*All but $[219] a day*	*$[219] a day*	*$0*
91st day and after:			
—While using 60 lifetime reserve days	*All but $[438] a day*	*$[438] a day*	*$0*
—Once lifetime reserve days are used:			
—Additional 365 days	*$0*	*100% of Medicare eligible expenses*	*$0****
—Beyond the additional 365 days	*$0*	*$0*	*All costs*
*SKILLED NURSING FACILITY CARE***			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility			
Within 30 days after leaving the hospital			
First 20 days	*All approved amounts*	*$0*	*$0*
21st thru 100th day	*All but $[109.50] a day*	*Up to $[82.13] a day*	*Up to $[27.37] a day♦*
101st day and after	*$0*	*$0*	*All costs*
BLOOD			
First 3 pints	*$0*	*75%*	*25%♦*
Additional amounts	*100%*	*$0*	*$0*

HOSPICE CARE *Available as long as your doctor certifies you are terminally ill and you elect to receive these services*	*Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care*	*75% of coinsurance or copayments*	*25% of coinsurance or copayments ♦*

(continued)

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN L

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

***** Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare Approved Amounts****	$0	$0	$[100] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$2000])*
BLOOD			
First 3 pints	$0	75%	25%♦
Next $[100] of Medicare Approved Amounts****	$0	$0	$[100] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

**** This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[2000] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.***

PLAN L

PARTS A & B

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY**
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	*100%*	*$0*	*$0*
*—Durable medical equipment First $[100] of Medicare Approved Amounts*****	*$0*	*$0*	*$[100] (Part B deductible) ♦*
Remainder of Medicare Approved Amounts	*80%*	*15%*	*5% ♦*

*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.*

*[(D)]***(E)** Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

1. Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy**,** a policy issued pursuant to a contract under section 1876 of the Federal Social Security Act (42 U.S.C. 1395 et seq.), disability income policy; or other policy identified in subsection (1)(B) of this rule, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve (12)-point type and shall contain the following language: "THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

2. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in paragraph *[(D)]***(E)**1. of this section shall disclose, using the applicable statement in Appendix C, **included herein,** the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

(16) Requirements for Application Forms and Replacement Coverage.

(A) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant **currently** has *[another]* Medicare supplement, **MedicareAdvantage, Medicaid coverage,** or *[other]* **another** health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and *[agent]* **insurance producer** containing such questions and statements may be used.

Statements:

1. You do not need more than one Medicare supplement policy.

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

4. **If, after purchasing this policy, you become eligible for Medicaid,** *[T]***t**he benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for twenty-four (24) months. You must request this suspension within ninety (90) days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your **suspended Medicare supplement** policy **(or, if that is no longer available, a substantially equivalent policy)** will be reinstituted if requested within ninety (90) days of losing Medicaid eligibility. **If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.**

5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety (90) days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

*[5.]***6.** Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). Questions:

[To the best of your knowledge,

1. Do you have another Medicare supplement policy or certificate in force?

A. If so, with which company?

B. If so, do you intend to replace your current Medicare supplement policy with this policy [certificate]?

2. Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?

A. If so, with which company?

B. What kind of policy?

3. Are you covered for medical assistance through the state Medicaid program:

A. As a Specified Low-Income Medicare Beneficiary (SLMB)?

B. As a Qualified Medicare Beneficiary (QMB)?

C. For other Medicaid medical benefits?]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

(Please mark Yes or No below with an "X")

To the best of your knowledge,

(1)

(a) Did you turn age 65 in the last 6 months?

Yes____ No____

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes____ No____

(c) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a "Spend-down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes____ No____

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes____ No____

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes____ No____

(3)

(a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START __/__/__ END __/__/__

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes____ No____

(c) Was this your first time in this type of Medicare plan?

Yes____ No____

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes____ No____

(4)

(a) Do you have another Medicare supplement policy in force?

Yes____ No____

(b) If so, with what company, and what plan do you have [optional for Direct Mailers]?

_____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes____ No____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes____ No____

(a) If so, with what company and what kind of policy?

_____
_____
_____
_____

(b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.

START __/__/__ END __/__/__

(B) *[Agents]* **Insurance producers** shall list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.

2. List policies sold in the past five (5) years which are no longer in force.

(D) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its *[agent]* **insurance producer**, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of the notice signed by the applicant and the *[agent]* **insurance producer,** except where the coverage is sold without an *[agent]* **insurance producer,** shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(E) The notice required by subsection (D) above for an issuer shall be provided in substantially the following form in no less than twelve (12)-point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICAREADVANTAGE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement **or MedicareAdvantage coverage**. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, *[AGENT BROKER]* **INSURANCE PRODUCER** [OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason (check one):

____ Additional benefits.

____ No change in benefits, but lower premiums.

____ Fewer benefits and lower premiums.

____ **Disenrollment from a MedicareAdvantage plan. Please explain reason for disenrollment (optional only for Direct Mailers)**

_____

_____

_____

____ Other. (please specify)

1. **NOTE: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below.** Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

(Signature of *[Agent, Broker]* **Insurance Producer** or Other Representative)*

[Typed Name and Address of Issuer, *[Agent or Broker]* **Insurance Producer]**

_____

(Applicant's Signature)

_____

(Date)

*Signature not required for direct response sales.

(18) Standards for Marketing.

(A) An issuer, directly or through its producers, shall—

1. Establish marketing procedures to assure that any comparison of policies by its *[agents or other producers]* **insurance producers** will be fair and accurate;

2. Establish marketing procedures to assure excessive insurance is not sold or issued;

3. Display prominently by type, stamp or other appropriate means, on the first page of the policy the following: **"Notice to buyer: This policy may not cover all of your medical expenses.";**

4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance; and

5. Establish auditable procedures for verifying compliance with this subsection (A).

(B) In addition to the practices prohibited in the Unfair Trade Practices Act (sections 375.930 to 375.948, RSMo) and the Unfair Claim Settlement Practices Act (sections 375.1000 to 375.1018, RSMo), the following acts and practices are prohibited:

1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer;

2. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance; and

3. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance *[agent]* **producer** or insurance company.

(19) Appropriateness of Recommended Purchase and Excessive Insurance.

(A) In recommending the purchase or replacement of any Medicare supplement policy or certificate an *[agent]* **insurance producer** shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(C) *[Any sale of Medicare supplement insurance to a person enrolled in a Medicare + Choice plan is prohibited.]* **An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.**

[(23) Effective Date. This rule shall be effective thirty days after publication in the Missouri Code of State Regulations.]

APPENDIX A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR _____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

Line		(a) Earned Premium[3]	(b) Incurred Claims[4]
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues[5]		
	c. Net (for reporting purposes = 1a–1b		
2.	Past Years' Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		
4.	Refunds Last Year (Excluding Interest)		
5.	Previous Since Inception (Excluding Interest)		
6.	Refunds Since Inception (Excluding Interest)		
7.	Benchmark Ratio Since Inception (*see worksheet for Ratio 1*)		
8.	Experienced Ratio Since Inception (*Ratio 2*) Total Actual Incurred Claims (line 3, col. b) / Total Earned Prem. (line 3, col. a) Refunds Since Inception (line 6)		
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.		
10.	Tolerance Permitted (obtained from credibility table)		

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000 +	0.0%
5,000 -9,999	5.0%
2,500 -4,999	7.5%
1,000 -2,499	10.0%
500 - 999	15.0%
If less than 500, no credibility.	

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for *[pre-standardized]* **prestandardized** plans.
3 Includes Modal Loadings and Fees Charged
4 Excludes Active Life Reserves
5 This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

11.	Adjustment to Incurred Claims for Credibility Ratio 3 = Ratio 2 ÷ Tolerance	

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required. If Ratio 3 is less than the Benchmark Ratio, then proceed.

12.	Adjusted Incurred Claims [Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6)] x Ratio 3 (line 11)	
13.	Refund = Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6) –[Adjusted Incurred Claims (line 12)/Benchmark Ratio (Ratio 1)]	

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR GROUP POLICIES
FOR CALENDAR YEAR _____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15+[6]		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans

[3] Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

[4] For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

[5] These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

[6] ***To include the earned premium for all years prior to as well as the 15th year prior to the current year.***

REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+[6]		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans

[3] Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

[4] For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

[5] These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

[6] ***To include the earned premium for all years prior to as well as the 15th year prior to the current year.***

APPENDIX B

FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

_____

Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

APPENDIX C

DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

1. Section 1882 (d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- ***[outpatient prescription drugs if you are enrolled in Medicare Part D]***
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program

[Original disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- ***[outpatient prescription drugs if you are enrolled in Medicare Part D]***
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state *[[senior]]* ***[health]*** insurance *[[counseling]]* ***[assistance]*** program ***[SHIP]***.

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- ***[outpatient prescription drugs if you are enrolled in Medicare Part D]***
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state *[[senior]]* ***[health]*** insurance *[[counseling]]* ***[assistance]*** program ***[SHIP]***.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- ***[outpatient prescription drugs if you are enrolled in Medicare Part D]***
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state *[[senior]]* ***[health]*** insurance *[[counseling]]* ***[assistance]*** program ***[SHIP]***.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- ***[outpatient prescription drugs if you are enrolled in Medicare Part D]***
- hospice
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state *[[senior]]* ***[health]*** insurance *[[counseling]]* ***[assistance]*** program ***[SHIP]***.

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- ***[outpatient prescription drugs if you are enrolled in Medicare Part D]***
- other approved items & services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state *[[senior]]* ***[health]*** insurance *[[counseling]]* ***[assistance]*** program.

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- ***[outpatient prescription drugs if you are enrolled in Medicare Part D]***
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state *[[senior]]* ***[health]*** insurance *[[counseling]]* ***[assistance]*** program.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- ***[outpatient prescription drugs if you are enrolled in Medicare Part D]***
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state *[[senior]]* ***[health]*** insurance *[[counseling]]* ***[assistance]*** program.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- ***[outpatient prescription drugs if you are enrolled in Medicare Part D]***
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state *[[senior]]* ***[health]*** insurance *[[counseling]]* ***[assistance]*** program.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- ***[outpatient prescription drugs if you are enrolled in Medicare Part D]***
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state *[[senior]]* ***[health]*** insurance *[[counseling]]* ***[assistance]*** program.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- ***[outpatient prescription drugs if you are enrolled in Medicare Part D]***
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state *[[senior]]* ***[health]*** insurance *[[counseling]]* ***[assistance]*** program.

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- ***[outpatient prescription drugs if you are enrolled in Medicare Part D]***
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state *[[senior]]* ***[health]*** insurance *[[counseling]]* ***[assistance]*** program.

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- ***[outpatient prescription drugs if you are enrolled in Medicare Part D]***
- other approved items & services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state *[[senior]]* ***[health]*** insurance *[[counseling]]* ***[assistance]*** program.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- ***[outpatient prescription drugs if you are enrolled in Medicare Part D]***
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or your state *[[senior]]* ***[health]*** insurance *[[counseling]]* ***[assistance]*** program.

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

*AUTHORITY: section[s 376.864.3, 376.864.4, 376.864.5, 376.879 and 376.886 RSMo Supp. 1998 and 376.874, RSMo 1994] 374.045, **RSMo 2000**. Original rule filed Oct. 15, 1998, effective June 30, 1999. Emergency amendment filed May 16, 2005, effective June 1, 2005, expires Feb. 2, 2006. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo Supp. 2004.

EXECUTIVE ORDER
05-14

WHEREAS, traffic and motor vehicle crashes cause numerous personal injuries and fatalities, as well as extensive property damage; and

WHEREAS, according to the National Traffic Safety Administration (NTSA), an average of 135 people die annually in school transportation related crashes, including an average of 22 school-age children fatalities per year; and

WHEREAS, according to traffic crash reports, nearly four school bus crashes a day occur in Missouri; and

WHEREAS, a fatal school bus crash occurred on May 12, 2005 in Liberty, Missouri, killing two people and injuring several students, sending two to the hospital; and

WHEREAS, also on May 12, 2005, a train struck a school bus from the Wentzville School District during a field trip to Hannibal, causing minor injuries to some of the 37 people aboard the bus; and

WHEREAS, the safety of school children who ride school buses must be a top priority of both state and local government officials.

NOW THEREFORE, I, Matt Blunt, Governor of Missouri, by virtue and authority vested in me by the Constitution and laws of the State of Missouri, do hereby create and establish the Missouri School Bus Safety Task Force.

The Task Force shall consist of nine (9) members appointed by the Governor. The Governor shall designate one (1) member to serve as chair. All members shall serve at the pleasure of the Governor.

Members of the Task Force shall receive no compensation for their service to the people of Missouri but may seek reimbursement for their reasonable and necessary expenses incurred as members of the Task Force, in accordance with the rules and regulations of the Office of Administration, to the extent that funds are available for such purpose.

The Task Force is assigned for administrative purposes to the Missouri Department of Transportation. The Director of the Missouri Department of Transportation shall be available to assist the Task Force as necessary, and shall provide the Task Force with any staff assistance the Task Force may require from time to time.

The Task Force shall meet at the call of its Chair, and the Chair shall call the first meeting of the Task Force as soon as possible.

The Task Force shall evaluate and make initial recommendations to me by August 15, 2005 on the following topics:

- Developing strategies for improving school bus safety, including, but not limited to, programs or laws that have proven effective to reduce the incidents of school transportation-related accidents;
- Analyzing current state and federal laws and programs governing school bus safety and recommending any changes that would enhance the effectiveness of these laws or programs;
- Reviewing whether requiring seat belts in school buses would prove effective in reducing fatalities and injuries in school transportation-related accidents;
- Recommending specific school bus safety legislation for possible consideration by the Missouri General Assembly; and
- Recommending best practices or policies that could be implemented by state or local governments that would enhance school bus safety.

The Task Force shall prepare a final report and submit it to me by December 31, 2005.

The Task Force shall expire on December 31, 2005.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 17th day of May, 2005.

Matt Blunt
Governor

ATTEST:

Robin Carnahan
Secretary of State

Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbology under the heading of the proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register.* If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety (90)-day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:
Boldface text indicates new matter.
[Bracketed text indicates matter being deleted.]

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 30—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 5—Examinations

PROPOSED RESCISSION

4 CSR 30-5.030 Standards for Admission to Examination Architects. This rule set out standards for admission to architectural examinations.

PURPOSE: This rule is being rescinded and readopted to bring the rule language into compliance with section 327.131, RSMo as amended by HB 567 of the 91st General Assembly (2001).

AUTHORITY: section 327.041, RSMo Supp. 1989. Original rule filed March 16, 1970, effective April 16, 1970. Amended: Filed Dec. 8, 1981, effective March 11, 1982. Amended: Filed Sept. 13, 1983, effective Dec. 11, 1983. Amended: Filed Sept. 12, 1985, effective Dec. 12, 1985. Amended: Filed Feb. 4, 1992, effective June 25, 1992. Rescinded: Filed May 13, 2005.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via e-mail at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 30—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 5—Examinations

PROPOSED RULE

4 CSR 30-5.030 Standards for Admission to Examination—Architects

PURPOSE: This rule sets out standards for admission to architectural examinations.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Every graduate from a curriculum fully accredited by the National Architectural Accreditation Board (NAAB), or other designated agencies as recognized by the National Council of Architectural Registration Boards (NCARB), who shall apply for architectural licensure shall submit with and as a part of the application documents as required in section 327.131, RSMo, a fully certified and completed Intern Development Program (IDP) record.

(2) Prior to January 1, 2012, every nongraduate applying for architectural licensure shall submit with and as part of the application documents as required in section 327.131, RSMo, a weekly record or log of diversified architectural experience covering a period of not fewer than two hundred eight (208) weeks immediately prior to application. Every weekly record or log shall be witnessed by the signature of a licensed architect having direct personal supervision of that experience. In addition to the experience log, there also shall be included in the application a chronological list of the education and architectural experience the applicant claims prior to the period of

the log which will furnish a total of eight (8) years of architectural experience.

(3) The standard for satisfactory architectural experience shall be the criteria set forth in the National Council of Architectural Registration Board's Circular of Information No. 1, Appendix A dated 1990–1991, which is incorporated herein by reference. A copy of the information may be obtained by contacting the National Council of Architectural Registration Boards, 1801 K Street NW, Suite 1100, Washington DC 20006-1301. The referenced material does not include any later amendments or additions.

(4) The standard for satisfactory architectural education shall be the criteria set forth in the National Council of Architectural Registration Board's Circular of Information No. 1, Appendix A dated 1978, which is incorporated herein by reference. A copy of the information may be obtained by contacting the National Council of Architectural Registration Boards, 1801 K Street NW, Suite 1100, Washington DC 20006-1301. The referenced material does not include any later amendments or additions.

AUTHORITY: section 327.041, and *327.121, 327.131, RSMo Supp. 2004 and 327.141, RSMo 2000. Original rule filed March 16, 1970, effective April 16, 1970. For intervening history, please consult the* ***Code of State Regulations****. Rescinded and readopted: Filed May 13, 2005.*

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions approximately one thousand one hundred eleven dollars and seventy-six cents ($1,111.76) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE COST: This proposed rule will cost private entities approximately three thousand two hundred eleven dollars and eighty-four cents ($3,211.84) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via e-mail at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

PUBLIC ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development

Division 30 - Missouri Board for Architects, Professional Engineers, Professional Land Surveyors and Landscape Architects

Chapter 5 - Examinations

Proposed Rule - 4 CSR 30-5.030 Standards for Admission to Examination - Architects

Prepared March 29, 2005 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Annual Cost of Compliance
Missouri Board for Architects, Professional Engineers, Professional Land Surveyors and Landscape Architects	$1,111.76
Total Annual Cost of Compliance for the Life of the Rule	**$1,111.76**

III. WORKSHEET

CALCULATION OF EXPENSE AND EQUIPMENT AND PERSONAL SERVICE COSTS:
Licensure Technician IIs will perform the follow duties:
· **APPLICATIONS FOR ARCHITECTURAL LICENSURE** - Review application for completeness, update division's licensing system, prepare and sends follow up letters, respond to telephone inquiries, process all documentation and issue and mail the license.
· **APPLICATIONS FOR NON-GRADUATES** - Review application for completeness, update division's licensing system, prepare and send follow up letters, respond to telephone inquiries, process all documentation, prepare application for board review, notify applicant of any deficiencies noted by the board, schedule applicant for the examination and issue and mail the license.

APPLICATIONS FOR ARCHITECTURAL LICENSURE

STAFF	ANNUAL SALARY	SALARY TO INCLUDE FRINGE BENEFIT	HOURLY SALARY	COST PER MINUTE	TIME PER APPLICATION	COST PER APPLICATION	TOTAL COST
Licensing Technician II	$26,292	$36,932	$17.76	$0.30	30 minutes	$8.88	$177.56

APPLICATIONS FOR NON GRADUATES

STAFF	ANNUAL SALARY	SALARY TO INCLUDE FRINGE BENEFIT	HOURLY SALARY	TIME PER APPLICATION	COST PER APPLICATION	TOTAL COST
Licensing Technician II	$26,292	$36,932	$17.76	4 hours	$71.02	$852.29
				Total Personal Service Costs		**$1,029.84**

Expense and Equipment and Personal Service Dollars	
Application Printing	$0.80
Letterhead Printing	$0.15
Envelope for Mailing Application	$0.16
Postage for Mailing Application	$1.03
Printing of Registration	$0.05
Postage for Mailing registration	$0.37
Total Per Applicant:	$2.56

Total Expense and Equipment Costs: $81.92

IV. ASSUMPTION

1. Based on FY04 actuals and FY05 projections, the board anticipates 20 applications for architectural licensure and 12 non graduate applications will be received annually.
2. Employee's salaries were calculated using their annual salary multiplied by 40.47% for fringe benefits and then were divided by 2080 hours per year to determine the hourly salary. The hourly salary was then divided by 60 minutes to determine the cost per minute. The cost per minute was then multiplied by the amount of time the Licensure Technician II spent on the processing of the application. The total cost was based on the cost per request multiplied by the estimated number of requests received on an annual basis.
3. Applications for non-graduates are currently reviewed by the members of the board at their regularly scheduled board meetings, therefore, no additional per diem is included in this fiscal note.
4. It is anticipated that the total cost will recur annually for the life of the rule, may vary with inflation and is expected to increase annually at the rate projected by the Legislative Oversight Committee.

NOTE: The public fiscal note for this rule only reflects the cost for this particular process. However, private entity fees are set at an amount to cover the total actual cost incurred by the board, which includes personal service, expense and equipment and transfers.

PRIVATE ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development

Division 30 - Missouri Board for Architects, Professional Engineers, Professional Land Surveyors and Landscape Architects

Chapter 5 - Examinations

Proposed Rule - 4 CSR 30-5.030 Standards for Admission to Examination - Architects

Prepared March 29, 2005 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimated cost of compliance with the rule by affected entities:
32	Applicants (application fee @ $100)	$3,200.00
32	Applicants (notary @ $2.50)	$80.00
32	Applicants (postage @ $.37)	$11.84
	Estimated Annual Cost of Compliance for the Life of the Rule	**$3,211.84**

III. WORKSHEET

See table above.

IV. ASSUMPTION

1. Based on FY04 actuals and FY05 projections, the board anticipates 20 applications for architectural licensure and 12 non graduate applications will received annually.
2. It is anticipated that the total cost will recur annually for the life of the rule, may vary with inflation and is expected to increase annually at the rate projected by the Legislative Oversight Committee

NOTE: The board is statutorily obligated to enforce and administer the provisions of Chapter 326, RSMo. Pursuant to Section 326.319, RSMo, the board shall by rule and regulation set the amount of fees authorized by Chapter 326, RSMo so that the revenue produced is sufficient, but not excessive, to cover the cost and expense to the board for administering the provisions of Chapter 326, RSMo. This proposed amendment is necessary because the board's projected revenue will not support the expenditures necessary to enforce and administer the provisions of Chapter 326, RSMo, which will result in an endangerment to the health, welfare, and safety of the public.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 30—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 5—Examinations

PROPOSED AMENDMENT

4 CSR 30-5.080 Standards for Admission to Examination—Engineers. The board is proposing to amend sections (1) and (3), add new language in section (4), renumber the remaining sections accordingly, and amend the newly renumbered sections (6)–(8).

PURPOSE: This rule sets out standards for admission to engineering examinations. It is being amended to require foreign-educated applicants to have their educational credentials evaluated by the Engineering Credentials Evaluation International (ECEI) and to provide clarification of the evaluation process. It also deletes reference to the doctorate degree and addresses several other minor housecleaning issues.

(1) Before being admitted to the examination, an applicant for *[registration]* **licensure** as a professional engineer shall have the knowledge, skills and experience as the board deems necessary to qualify the applicant for being placed in responsible charge of engineering work. The minimum length of experience required of the applicant, based on education, is three (3) years for any applicant holding a master's degree *[or a doctorate degree]* in engineering; however, an applicant will not be admitted to **the** examination sooner than four (4) years after the applicant has satisfied the educational requirements of sections 327.221 and 327.241, RSMo, provided, however, any applicant who shall have been conferred a master's degree *[or doctorate degree]* in engineering concurrently while acquiring three (3) years of satisfactory engineering experience, as provided in this rule, shall be admitted to the examination. The Engineers' Council for Professional Development (ECPD) has been succeeded by the Accreditation Board for Engineering and Technology, Inc. (ABET). For purposes of evaluating engineering curricula at the baccalaureate level, the programs accredited by the Engineering Accreditation Commission (EAC) of ABET shall be the basis used for evaluation of programs not accredited by EAC of ABET.

(3) *[When an engineering curriculum has not been accredited by ECPD, ABET, or its successor organizations, the professional engineering division shall evaluate the educational program of the applicant in order to determine whether or not, in its opinion, the educational program is equal to or exceeds the programs accredited by ECPD, ABET, or their successor organizations. The professional engineering division shall select one (1) registered engineer experienced in evaluating academic credentials to assist in making this determination.]* **Foreign-educated applicants holding an engineering degree not accredited by ECPD, ABET, or its successor organizations will be required to submit a favorable evaluation report completed by the Engineering Credentials Evaluation International (ECEI) or by another evaluation service acceptable by the professional engineering division of the board certifying equivalency to an ABET accredited degree. Applicants holding a United States of America (U.S.A.) engineering degree not accredited by ECPD, ABET, or its successor organizations will be required to have their educational degree program evaluated in order to determine whether or not it is equal to or exceeds the programs accredited by ECPD, ABET, or their successor organizations. The evaluation must be completed by an engineer(s) experienced in evaluating academic credentials selected by the professional engineering division or by an evaluation service acceptable by the professional engineering division of the board.** The evaluator, by evaluation of transcripts and an official publication describing the engineering degree program of the institution, personal interview, by examination, or both in any other manner deemed suitable, shall make an evaluation as to whether the academic program completed by the applicant meets the minimum educational requirements established by section 327.221, RSMo. The evaluator shall recommend to the professional engineering division and report how any deficiencies can be corrected, listing prescribed educational areas to bring the applicant's academic qualifications up to the required minimum. The report of the evaluator shall not be binding upon the division.

(4) A degree in engineering technology does not meet the educational requirements of section 327.221, RSMo.

*[(4)]***(5)** Any applicant deemed by the professional engineering division under section (3) of this rule to have completed an educational program which is equal to or exceeds those programs accredited by ECPD, ABET, or their successor organizations shall be required to have obtained the minimum engineering work experience as is required in section (1) of this rule. In all cases, the board will consider only that experience the applicant has obtained after satisfying the educational requirements of sections 327.221 and 327.241, RSMo.

*[(5)]***(6)** In evaluating the minimum engineering work experience required of all applicants, the professional engineering division shall grant maximum credit as follows:

(A) Engineering teaching at collegiate level (only advanced engineering subjects or courses related to advanced engineering at board-approved schools), assistant professor and higher—year-for-year;

(B) *[Graduate education, m]***M**aster's degree *[or PhD degree]* **in engineering—**one (1) year for completion *[of either]*;

(C) Military service (commissioned only—normally this service is in a technical branch such as engineering, ordinance, civil work services (CWS), civil engineering corps (CEC), etc.): Generally year-for-year subject to evaluation;

(D) Construction (technical decision-making level), above average complexity, non-standard design, or both involving field modification—year-for-year;

(E) Project planning including layout and twenty-five percent (25%) or more design—year-for-year;

(F) Research and development at the planning and decision-making level—year-for-year; and

(G) Engineering management and administration—year-for-year.

[(6)] **(7)** Individual evaluation may result in less than full credit.

[(7)] **(8)** In accordance with the authority conferred upon the board at section 327.241.6., RSMo, the board provides that any person, upon satisfactory showing of an urgent need, such as absence from the United States, economic hardship or professional necessity, and who has graduated from and holds an engineering degree from an accredited school of engineering, and has acquired at least three and one-half (3 1/2) years of satisfactory experience, and previously has been classified an engineer-in-training **or engineer-intern** by having successfully passed the first part of the examination, shall be eligible to take the second part of the examination and, upon passing, shall be entitled to receive a certificate of *[registration]* **licensure** to practice as a professional engineer subject, however, to other provisions of Chapter 327, RSMo, including having acquired four (4) years of satisfactory experience.

AUTHORITY: sections 327.041, RSMo [1994] ***Supp. 2004 and 327.221, and 327.241, RSMo 2000.*** *Original rule filed March 16, 1970, effective April 16, 1970. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed May 13, 2005.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions approximately three thousand dollars ($3,000) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE COST: This proposed amendment will cost private entities approximately eight thousand six hundred twenty-nine dollars ($8,629.15) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via e-mail at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

PUBLIC ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development

Division 30 - Missouri Board for Architects, Professional Engineers, Professional Land Surveyors and Landscape Architects

Chapter 5 - Examinations

Proposed Rule - 4 CSR 30-5.080 Standards for Admission to Examination - Engineers

Prepared March 29, 2005 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Annual Cost of Compliance
Missouri Board for Architects, Professional Engineers, Professional Land Surveyors and Landscape Architects	$3,000.00
Total Annual Cost of Compliance for the Life of the Rule	$3,000.00

III. WORKSHEET

See Assumptions

IV. ASSUMPTION

1. Based on FY05 projections, the board is estimating that approximately 20 applicants holding United States of America (U.S.A.) engineering degree not accredited by ECPD, ABET, or its successor organizations will be required to have their educational degree program evaluated in order to determine whether or not it is equal to or exceeds the programs accredited by ECPD, ABET, or their successor organizations. The board will collect $300 from each applicant of which $150 will be considered a pass through fee for the evaluator. Therefore, it is estimated that the board will pay the evaluator $3,000 annually to complete the education evaluations.

2. It is anticipated that the total cost will recur annually for the life of the rule, may vary with inflation and is expected to increase annually at the rate projected by the Legislative Oversight Committee.

NOTE: The public fiscal note for this rule only reflects the cost for this particular process. However, private entity fees are set at an amount to cover the total actual cost incurred by the board, which includes personal service, expense and equipment and transfers.

PRIVATE ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development

Division 30 - Missouri Board for Architects, Professional Engineers, Professional Land Surveyors and Landscape Architects

Chapter 5 - Examinations

Proposed Rule - 4 CSR 30-5.080 Standards for Admission to Examination - Engineers

Prepared March 29, 2005 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimated cost of compliance with the rule by affected entities:
25	Applicants - foreign educated (application fee @ $100)	$2,500.00
20	Applicants - U.S. non accredited engineering degree (application fee @ $300)	$6,000.00
45	Applicants (notary @ $2.50)	$112.50
45	Applicants (postage @ $.37)	$16.65
	Estimated Annual Cost of Compliance for the Life of the Rule	**$8,629.15**

III. WORKSHEET

See table above.

IV. ASSUMPTION

1. Based on FY05 projections the board estimates 25 foreign-educated applicants holding an engineering degree not accredited by ECPD, ABET, or its successor organizations will be required to submit a favorable evaluation report completed by the Engineering Credentials Evaluation International (ECEI). The ECEI offers several levels of service for various fees, which include basic service, rush service, etc. For the purpose of this fiscal note, the board is using the basic service fee of $425. It should be noted that this could be a cost savings for applicants as the evaluation report can be used for many states to meet the educational requirements versus having to pay each state individually for an educational review.

2. It is anticipated that the total cost will recur annually for the life of the rule, may vary with inflation and is expected to increase annually at the rate projected by the Legislative Oversight Committee.

NOTE: The board is statutorily obligated to enforce and administer the provisions of Chapter 326, RSMo. Pursuant to Section 326.319, RSMo, the board shall by rule and regulation set the amount of fees authorized by Chapter 326, RSMo so that the revenue produced is sufficient, but not excessive, to cover the cost and expense to the board for administering the provisions of Chapter 326, RSMo. This proposed amendment is necessary because the board's projected revenue will not support the expenditures necessary to enforce and administer the provisions of Chapter 326, RSMo, which will result in an endangerment to the health, welfare, and safety of the public.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 30—Missouri Board for Architects, Professional Engineers, *[and]* Professional Land Surveyors, *and Landscape Architects*
Chapter 8—Land Surveying

PROPOSED AMENDMENT

4 CSR 30-8.020 Professional Land Surveyor—Professional Development Units. The board is proposing to amend section (1).

PURPOSE: This amendment requires a land surveyor to obtain a certain number of continuing education credits in Minimum Standards and limits the number of noncontact professional development units.

(1) Each licensed professional land surveyor, as a condition for renewal of his/her license, shall complete a minimum of twenty (20) professional development units (PDU) each two (2)-year period immediately preceding renewal, except as provided in section (2) of this rule.

(A) Of the required professional development units, licensed professional land surveyors shall complete a minimum of four (4) professional development units in Minimum Standards (4 CSR 30, Chapters 16, 17 and 19) during the four (4)-year period immediately preceding renewal.

(B) Of the required professional development units in the two (2)-year renewal period, not more than twelve (12) shall be obtained in nonpersonal contact activities. Nonpersonal contact activities include correspondence courses, video and televised courses, Internet and e-mail courses, or other activities where the presenter is not in physical proximity to the attendee.

*AUTHORITY: section 327.041, RSMo [2000] **Supp. 2004**. Original rule filed Dec. 8, 1981, effective March 11, 1982. For intervening history, please consult the **Code of State Regulations**. Amended: Filed May 13, 2005.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via e-mail at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 30—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 10—Corporations

PROPOSED RESCISSION

4 CSR 30-10.010 Application for Certificate of Authority. This rule established standards for corporations to obtain and maintain certificates of authority.

PURPOSE: This rule is being rescinded and readopted in order to change the term "person in responsible charge" to "managing agent" and define the agent's responsibilities and when a certificate of authority is not required.

AUTHORITY: sections 327.041, RSMo Supp. 2001 and 327.401, RSMo 2000. Original rule filed Dec. 8, 1981, effective March 11, 1982. Amended: Filed Oct. 30, 2002, effective April 30, 2003. Rescinded: Filed May 13, 2005.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via e-mail at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 30—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 10—Corporations

PROPOSED RULE

4 CSR 30-10.010 Application for Certificate of Authority

PURPOSE: This rule establishes standards for corporations to obtain and maintain certificates of authority.

(1) A corporation desiring a certificate of authority authorizing it to render architectural, professional engineering, land surveying or landscape architectural services in this state shall submit an application to the executive director of the board, listing the names and addresses of all officers and directors for a corporation or members and managers for a limited liability company. It shall also list the managing agent for each profession who is licensed in this state to practice architecture, engineering, surveying or landscape architecture.

(2) The managing agent shall be an owner, officer, partner, or a full-time employee. If the managing agent is also the person providing immediate personal supervision, as defined by board rule(s) 4 CSR 30-13.010 and/or 4 CSR 30-13.020, then that person must work in the same office where the work is being performed.

(3) The managing agent's responsibilities include:

(A) Renewal of the certificate of authority and notification to the board of any changes in the firm;

(B) Overall supervision of the professional and licensing activities of the firm and its employees;

(C) Assurance that the firm institutes and adheres to policies that are in accordance with Chapter 327, RSMo and 4 CSR 30; and

(D) Assurance, in the case of multiple offices, that the requirements for immediate personal supervision, as defined by board rule(s) 4 CSR 30-13.010 and/or 4 CSR 30-13.020, are being met.

(4) A certificate of authority is not required by a principal firm if the work is being done by a subconsultant who is licensed in this state. The principal firm cannot advertise itself as being able to provide architecture, engineering, land surveying, or landscape architecture services, or include the names of those professions in the name of their firm unless exempted pursuant to section 327.101(7), RSMo or section 327.191(5), RSMo.

(5) A corporation which is currently authorized by this board to provide professional services may continue to renew its certificate of authority under the rules that were in effect prior to October 30, 2005 so long as the persons listed in the corporation's application do not change. If there is any change in any of the persons listed in the corporation's application, the provisions in this section, 4 CSR 30-10.010 shall apply. The change shall be reported on a new form and submitted to the executive director of the board within thirty (30) days after the effective day of the change.

AUTHORITY: section 327.041, RSMo Supp. 2004. Original rule filed Dec. 8, 1981, effective March 11, 1982. Amended: Filed Oct. 30, 2002, effective April 30, 2003. Rescinded and readopted: Filed May 13, 2005.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions approximately four thousand eight hundred ninety-five dollars and six cents ($4,895.06) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE COST: This proposed rule will cost private entities approximately one hundred forty-five thousand nine hundred thirty-seven dollars and ninety-one cents ($145,937.91) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via e-mail at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

PUBLIC ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development

Division 30 - Missouri Board for Architects, Professional Engineers, Professional Land Surveyors and Landscape Architects

Chapter 10 - Corporations

Proposed Rule - 4 CSR 30-10.010 Application for Certificate of Authority

Prepared March 29, 2005 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Annual Cost of Compliance
Missouri Board for Architects, Professional Engineers, Professional Land Surveyors and Landscape Architects	$4,895.06

Total Annual Cost of Compliance for the Life of the Rule **$4,895.06**

III. WORKSHEET

CALCULATION OF EXPENSE AND EQUIPMENT AND PERSONAL SERVICE COSTS:
Licensure Technician IIs will review corporation applications for completeness, update division's licensing system, prepare and send follow up letters, respond to telephone inquiries, process all documentation, prepare application for board review, notify applicant of any deficiencies noted by the board, schedule applicant for the examination and issue and mail the license.

STAFF	ANNUAL SALARY	SALARY TO INCLUDE FRINGE BENEFIT	HOURLY SALARY	COST PER MINUTE	TIME PER APPLICATION	COST PER APPLICATION	TOTAL COST
Licensing Technician II	$26,292	$36,932	$17.76	$0.30	30 minutes	$8.88	$1,518.13

Total Personal Service Costs **$1,518.13**

Expense and Equipment and Personal Service Dollars	
Application Printing	$0.80
Letterhead Printing	$0.15
Envelope for Mailing Application	$0.16
Postage for Mailing Application	$1.03
Printing of Registration	$0.05
Postage for Mailing registration	$0.37
Total Per Applicant:	$2.56

Total Expense and Equipment Costs: **$437.76**

In order to even out the board's cash flow, the board implemented a biennial split renewal for the FY04 renewal period. Licenses are generally renewed for a 2 year period depending on the year of issuance (even or odd). The divisions central processing unit processes the renewal applications for the board. During FY04 the board transferred approximately $15,242.56 to the division to cover the cost of this service. In order to calculate the fiscal impact of this rule, the board estimates that approximately 944 certificates of authority were renewed representing approximately 7% of the total licensee renewed that fiscal year. Therefore, the board estimates that of the $15,242.56, approximately $1,066.97 was for the processing of corporation renewals in FY04.

Renewal Processing **$1,066.97**

Expense and Equipment and Personal Service Dollars	
Application Printing	$0.03
Envelope for Mailing Application	$0.16
Postage for Mailing Application	$0.34
Printing of Certificate of Authority	$0.05
Postage for Mailing registration	$0.34
Total Per Applicant:	$0.92

Total Expense and Equipment Costs: **$1,872.20**

IV. ASSUMPTION

1. Based on FY04 actuals and FY05 projections, the board anticipates 1,118 corporation applications will be received biennially.
2. Employee's salaries were calculated using their annual salary multiplied by 40.47% for fringe benefits and then were divided by 2080 hours per year to determine the hourly salary. The hourly salary was then divided by 60 minutes to determine the cost per minute. The cost per minute was then multiplied by the amount of time the Licensure Technician II spent on the processing of the application. The total cost was based on the cost per request multiplied by the estimated number of requests received on an annual basis.
3. It is anticipated that the total cost will recur annually for the life of the rule, may vary with inflation and is expected to increase annually at the rate projected by the Legislative Oversight Committee.

NOTE: The public fiscal note for this rule only reflects the cost for this particular process. However, private entity fees are set at an amount to cover the total actual cost incurred by the board, which includes personal service, expense and equipment and transfers.

PRIVATE ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development

Division 30 - Missouri Board for Architects, Professional Engineers, Professional Land Surveyors and Landscape Architects

Chapter 10 - Corporations

Proposed Rule - 4 CSR 30-10.010 Application for Certificate of Authority

Prepared March 29, 2005 by the Division of Professional Registration

Annual

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimated cost of compliance with the rule by affected entities:
171	Applicants (corporation application fee @ $300)	$51,300.00
171	Applicants (postage @ $.37)	$63.27
472	Corporations (corporation renewal fee @ $200)	$94,400.00
472	Corporations (postage @ $.37)	$174.64
	Estimated Annual Cost of Compliance for the Life of the Rule	**$145,937.91**

III. WORKSHEET

See table above.

IV. ASSUMPTION

1. The figures above are based on FY04 actuals.
2. It is anticipated that the total cost will recur annually for the life of the rule, may vary with inflation and is expected to increase annually at the rate projected by the Legislative Oversight Committee

NOTE: The board is statutorily obligated to enforce and administer the provisions of Chapter 326, RSMo. Pursuant to Section 326.319, RSMo, the board shall by rule and regulation set the amount of fees authorized by Chapter 326, RSMo so that the revenue produced is sufficient, but not excessive, to cover the cost and expense to the board for administering the provisions of Chapter 326, RSMo. This proposed amendment is necessary because the board's projected revenue will not support the expenditures necessary to enforce and administer the provisions of Chapter 326, RSMo, which will result in an endangerment to the health, welfare, and safety of the public.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 30—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 21—Professional Engineering

PROPOSED RULE

4 CSR 30-21.010 Design of Fire Suppression Systems

PURPOSE: This rule requires the design of fire suppression systems to be designed, prepared, and sealed by a professional engineer.

(1) Pursuant to section 327.181, RSMo the design of fire suppression systems is engineering and therefore the plans for those systems must be designed, prepared, and sealed by a professional engineer. This can be accomplished two (2) ways:

(A) The design engineer seals the construction documents that specify the design and criteria for the fire suppression system, including sprinklers, fire alarms, and other suppression systems. The layout and sizing of these systems, done by a Level III Technician certified by the National Institute for Certification in Engineering Technologies (NICET) or a professional engineer, can be submitted as a shop drawing. These shop drawings may be sealed by a professional engineer. The design engineer must review and approve the shop drawings for compliance with the design and specifications shown on the construction documents; and

(B) If there is no design engineer for the fire suppression system, then the shop drawings for the sprinklers, fire alarms, and other suppression systems must be designed and prepared under the immediate personal supervision of a professional engineer. These shop drawings must be sealed by the professional engineer who prepared them.

(2) Nothing in this section shall prohibit the design engineer, at his/her discretion, to specify and require the shop drawings to be designed, prepared, and sealed, by a professional engineer.

AUTHORITY: section 327.041, RSMo Supp. 2004. Original rule filed May 13, 2005.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via e-mail at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 40—Office of Athletics
Chapter 3—Ticket Procedures

PROPOSED RESCISSION

4 CSR 40-3.011 Tickets and Taxes. This rule defined the procedures for printing, selling and counting tickets.

AUTHORITY: section 317.006, RSMo 2000. Original rule filed April 30, 1982, effective Sept. 11, 1982. Rescinded and readopted: Filed March 2, 1989, effective May 11, 1989. Amended: Filed July 25, 1994, effective Jan. 29, 1995. Rescinded and readopted: Filed Nov. 15, 2001, effective May 30, 2002. Rescinded: Filed May 13, 2005.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Office of Athletics, PO Box 1335, Jefferson City, MO 65102, by facsimile at (573)751-5649 or via e-mail at athletic@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 40—Office of Athletics
Chapter 3—Ticket Procedures

PROPOSED RULE

4 CSR 40-3.011 Tickets and Taxes

PURPOSE: This rule defines the procedures for printing, selling and counting tickets.

(1) The right of admission to a contest of professional boxing, professional wrestling, professional kickboxing, and professional full-contact karate shall not be sold or otherwise granted to a person or entity unless that person or entity is provided with a ticket.

(2) The promoter of a contest of professional boxing, professional wrestling, professional kickboxing, and professional full-contact karate shall:

(A) Prepare an inventory that identifies all tickets that were printed for the contest and that accounts for any tickets that are overprints, changes or extras;

(B) Sign the inventory acknowledging that the inventory is true and correct;

(C) Send the inventory to the office with the permit application; and

(D) Submit with the permit application, a copy of the contract if the event was sold in part or in whole by means of a contract or other agreement for a contracted or otherwise agreed amount on partial sale and/or a contracted amount.

(3) Every ticket shall have the price, the name of the promoter and the date of the contest.

(4) A notice specifying a change in ticket prices or the dates of a contest or a notice specifying an amendment to the contract value of a contest of professional boxing, professional wrestling, professional kickboxing, and professional full-contact karate shall be made in writing to the office within ten (10) business days of the event. The promoter shall obtain prior approval from the office for any date changes for the contest.

(5) A promoter shall not issue complimentary tickets for more than four percent (4%) of the seats in the house without the office's written authorization. The promoter shall be responsible to pay the athletic tax prescribed in section 317.006.1(3), RSMo, for all complimentary tickets over and above the four percent (4%) maximum cap on complimentary tickets. If the office approves the issuance of complimentary tickets over and above the four percent (4%) cap, the complimentary tickets that are exempt from the athletic tax shall be based on the lowest value complimentary tickets distributed. All complimentary tickets must indicate on the ticket that it is a complimentary ticket and its value had the ticket actually been purchased.

(6) A promoter shall be assessed the athletic tax prescribed in section 317.006.1(3), RSMo, for any complimentary ticket that the office allows to be distributed over the four percent (4%) maximum cap. The face value of the complimentary tickets over the four percent (4%) maximum cap shall be the same as other like tickets sold in that particular section of the venue.

(7) Each promoter shall provide a ticket and/or credential without charge to:

(A) Licensed contestants, seconds and managers who are engaged in a bout which is part of the contest of professional boxing, professional wrestling, professional kickboxing, and professional full-contact karate; and

(B) Journalists who are performing his/her duties as such. Each ticket issued to a journalist must be clearly marked "PRESS." No more tickets may be issued to journalists than will permit seating in the press area.

(8) Notwithstanding other provisions of law in this regulation, the promoter of a contest of professional boxing, professional wrestling, professional kickboxing, and professional full-contact karate shall admit to such contest the division director, executive director, administrator, and inspectors of the office, or authorized firefighters, police officers, security officers and any other individuals authorized by the office assigned to work the event, any referee, judge, timekeeper, ringside physician, and medical personnel who are independent contractors of the office who are assigned to the event and who presents photo identification and an official badge or other credential evidencing such status. The promoter of a contest and officials of the venue shall allow a person listed in this section full access to the site of the contest and dressing rooms.

(9) Tickets of different prices shall be printed on cardstock of distinctly different colors. The ticket stub shall indicate the price of the ticket.

(10) The inspector shall have supervision over the sale of tickets, ticket boxes and entrances and exits for the purpose of checking admission controls. All ticket stubs collected by a ticket taker shall be deposited in a lock box provided by the office or other containers approved by the office. The inspector shall ensure that all tickets are counted and that the final accounting includes the number of complimentary tickets, the face value of each ticket and the total number of each ticket price category sold and the gross receipts from all ticket sales.

(11) The final accounting shall be completed. The final accounting shall include the amount of tax due from the promoter to the office.

(12) Any promoter holding a license and permit under these rules shall pay the office five percent (5%) of its gross receipts, less state, county and city taxes, derived from admission charges. The gross receipts shall be the amount received from the face value of all tickets sold, any complimentary tickets redeemed in excess of the four percent (4%) cap, and the value of any contracted amount, if applicable.

(13) The promoter is liable for payment of the athletic tax prescribed in section 317.006.1(3), RSMo, based upon the gross receipts. Such payment shall be made within ten (10) days of the event or two (2) days prior to the promoter's next scheduled event in Missouri, whichever occurs first.

(14) The office's executive director, administrator or their designee shall collect all fees and taxes due.

AUTHORITY: section 317.006, RSMo 2000. Original rule filed April 30, 1982, effective Sept. 11, 1982. Rescinded and readopted: FIled March 2, 1989, effective May 11, 1989. Amended: Filed July 25, 1994, effective Jan. 29, 1995. Rescinded and readopted: Filed Nov. 15, 2001, effective May 30, 2002. Rescinded and readopted: Filed May 13, 2005.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will cost private entities approximately eight thousand five hundred dollars ($8,500) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Office of Athletics, PO Box 1335, Jefferson City, MO 65102, by facsimile at (573) 751-5649 or via e-mail at athletic@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

PRIVATE ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development
Division 40 - Division of Professional Registration/Office of Athletics
Chapter 3 -Ticket Procedures
Proposed Rule - 4 CSR 40-3.011 Ticket and Taxes
Prepared March 16, 2005 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed amendment:	Classification by type of the business entities which would likely be affected:	Estimated annual cost of compliance with the amendment by affected entities:
171	Promoter - Athletic Event Tickets (printing tickets @ $50/per event)	$8,550
	Estimated Annual Cost of Compliance for the Life of the Rule	**$8,550**

III. WORKSHEET

See table above.

IV. ASSUMPTION

1. The reported figures are based on actual figures from FY04 and projected figures in FY05.
2. Pursuant to section 317.006, the office shall assess a tax of five percent of the gross receipts derived from admission charges connected with the holding of any professional boxing, sparring, professional wrestling, professional kickboxing or professional full-contact karate contest in this state. The costs associated with this athletic tax was outlined in the legislative fiscal note that accompanied Senate Bill 524 (1996).
3. The total costs will recur each year for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 40—Office of Athletics
Chapter 4—Licensees and Their Responsibilities

PROPOSED RESCISSION

4 CSR 40-4.090 Contestants. This rule defined and clarified the duties and responsibilities of contestants.

PURPOSE: This rule is being rescinded and readopted to clarify the duties and responsibilities of contestants.

AUTHORITY: sections 317.006 and 317.015, RSMo 2000. Original rule filed April 30, 1982, effective Sept. 11, 1982. Rescinded and readopted: Filed March 2, 1989, effective May 11, 1989. Amended: Filed Nov. 15, 2001, effective May 30, 2002. Rescinded: Filed May 13, 2005.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Office of Athletics, PO Box 1335, Jefferson City, MO 65102, by facsimile at (573) 751-5649 or via e-mail at athletic@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 40—Office of Athletics
Chapter 4—Licensees and Their Responsibilities

PROPOSED RULE

4 CSR 40-4.090 Contestants

PURPOSE: This rule outlines the procedures for applying for and renewal of a license and clarifies the duties and responsibilities of contestants.

(1) An applicant applying for a license as a contestant shall:

(A) Complete an application as required in section (2) of 4 CSR 40-2.011. Any person who provides incorrect information in an application for license as a contestant may be disciplined by the office;

(B) Be at least sixteen (16) years of age;

(C) Submit a signed notarized affidavit from their legal guardian approving them to participate in a contest if he/she is under the age of eighteen (18);

(D) Disclose in writing on a form provided by the office a complete medical history including any prior or existing medical conditions;

(E) Within thirty (30) days of application for licensure successfully complete a physical examination by physician with the designation "medical doctor" or "doctor of osteopathy" and submit a written statement from the physician attesting to the physical and mental health of the applicant. The office may increase the thirty (30)-day limit under special circumstances approved by the office; and

(F) Submit a certified copy of medical tests performed by a certified laboratory verifying the applicant is not infected with the human immunodeficiency virus (HIV) or hepatitis B or C virus. The medical tests shall not be dated more than ninety (90) days before the application is submitted.

(2) A contestant applying for renewal of a license:

(A) Complete an application as required in section (2) of 4 CSR 40-2.011. Any person who provides incorrect information in an application for license as a contestant may be disciplined by the office;

(B) Disclose in writing on a form provided by the office a complete medical history including any prior or existing medical conditions;

(C) Within thirty (30) days of application for licensure successfully complete a physical examination by physician with the designation "medical doctor" or "doctor of osteopathy" and submit a written statement from the physician attesting to the physical and mental health of the licensee. The office may increase the thirty (30)-day limit under special circumstances approved by the office; and

(D) Submit a certified copy of medical tests performed by a certified laboratory verifying the licensee is not infected with the human immunodeficiency virus (HIV) or hepatitis B or C virus. The medical tests shall not be dated more than ninety (90) days before the application is submitted.

(3) An applicant or contestant who does not pass the physical examination or receives positive results from any of the tests required in sections (1) and (2) shall be denied the right to fight for that bout.

(4) All fees involved with medical examinations and/or tests required in sections (1) and (2), in addition to any drug test required in section (11), shall be the responsibility of the promoter, contestant or applicant.

(5) Submit a written statement from a physician with the designation "medical doctor" or "doctor of osteopathy" verifying a negative pregnancy if the applicant is female. The test shall be within seven (7) days of the scheduled contest.

(6) The office will issue an identification card to each boxing contestant for the purpose of registration pursuant to the Professional Boxing Safety Act of 1996, 15 U.S.C. section 6301 et seq., to each boxer who so applies. The boxer shall provide a recent photograph for the identification card and any other information that is requested by the office. An identification card may not be substituted for the license to engage in boxing held by the boxer.

(7) Each contestant for professional boxing, professional kickboxing or professional full-contact karate must be weighed in the presence of the public, his/her opponent, a representative of the office and an official representing the promoter, on scales approved by the office at any place designated by the office. If a contestant cannot be present at the designated time set by the office, a contestant shall waive his/her rights under this section.

(8) The contestant for professional boxing, professional kickboxing or professional full-contact karate must have all weights stripped from his/her body before he/she is weighed in, but male contestants may wear shorts. Female contestants may wear shorts and a sports bra.

(9) The office may require contestants to be weighed more than once for any cause deemed sufficient to the office.

(10) Immediately preceding the contest, at a time designated by the office, all contestants must pass a physical examination given by a physician licensed by the office, in accordance with the office's rules and regulations. A contestant who does not pass the physical examination shall be denied the right to fight for that bout.

(11) The office may require a contestant to submit to a drug test. Failure to submit to a drug test upon notification by an inspector may result in disciplinary action being taken against the contestant's license.

(12) A contestant licensed by the office may be required to submit to any medical examination or test ordered by the office prior to participation in a bout.

(13) A boxing contestant shall present his/her identification card to the office representative at weigh-in for a bout and at any other time ordered by the office or its representative. Failure to possess the card shall result in the boxing contestant being disallowed to participate in a bout.

(14) A boxing contestant licensed by the office is subject to disciplinary action by the office if the contestant knowingly:

(A) Provides false information for an identification card or falsifies or attempts to falsify an identification card, or aids in such acts;

(B) Uses or attempts to use an identification card in an unlawful manner or in a manner that is not in the best interests of professional boxing; or

(C) Otherwise violates the provisions of this section.

(15) Each contestant must report to the representative of the office in charge of dressing rooms at least thirty (30) minutes before the scheduled time of the first bout of professional boxing, professional wrestling, professional kickboxing, and professional full-contact karate contest. Failure to do so may result in the contestant being disallowed to participate in the bout.

(16) Contestants shall at all times abide by the statutes and rules of Missouri governing professional boxing, professional wrestling, professional kickboxing or professional full-contact karate.

(17) Contestants shall at all times observe the directions and decisions of all officials.

(18) A contestant of boxing may not have a promoter or any of its members, stockholders, officials, matchmakers or assistant matchmakers—

(A) Act directly or indirectly as his/her manager; or

(B) Hold any financial interest in his/her management or his/her earnings from each contest.

(19) Contestants for professional wrestling shall include anyone participating in any wrestling activities whether inside or outside the ring during a contest.

(20) The belt of the trunks must not extend above the waist line.

(21) Each boxing, full-contact karate or martial arts contestant must wear:

(A) A mouthpiece which has been individually fitted; and

(B) An abdominal protector which will protect him against injury from a foul blow.

(22) Each contestant must be clean and present a tidy appearance.

(23) The excessive use of petroleum jelly shall not be used on the face or body of a contestant. The referees or the office's representative in charge shall cause any excessive petroleum jelly to be removed.

(24) The office's representative shall determine whether head and facial hair presents any hazard to the safety of the contestant or his/her opponent or would interfere with the supervision and conduct of the bout. If the head and facial hair of the contestant present such a hazard or would interfere with the supervision and conduct of the bout, the contestant shall not compete in the bout unless the circumstances creating the hazard or potential interference are corrected to the satisfaction of the office's representative.

(25) A contestant may not wear any jewelry or other piercing accessories while competing in a bout.

(26) The office may honor the suspension of a contestant by an agency that regulates professional boxing, professional wrestling, professional kickboxing, and professional full-contact karate in another jurisdiction if the suspension is ordered for:

(A) Medical safety;

(B) A violation of a law or regulation governing professional boxing, professional kickboxing, and professional full-contact karate which also exists in this state; or

(C) Any other conduct which discredits professional boxing, professional kickboxing, and professional full-contact karate, as determined by the office.

AUTHORITY: sections 317.006 and 317.015, RSMo 2000. Original rule filed April 30, 1982, effective Sept. 11, 1982. Rescinded and readopted: Filed March 2, 1999, effective May 11, 1989. Amended: Filed Nov. 15, 2001, effective May 30, 2002. Rescinded and readopted: Filed May 13, 2005.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions approximately five hundred seventy dollars and seventy-five cents ($570.75) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE COST: This proposed rule will cost private entities approximately forty thousand seven hundred forty-six dollars ($40,746) annually and approximately one hundred eight thousand seven hundred fifty-six dollars ($108,756) biennially for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Office of Athletics, PO Box 1335, Jefferson City, MO 65102, by facsimile at (573) 751-5649 or via e-mail at athletic@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

PUBLIC ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development

Division 40 - Office of Athletics

Chapter 4 - Licensees and Their Responsibilities

Proposed Amendment - 4 CSR 40-4.090 Contestants

Prepared March 16, 2005 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Annual Cost of Compliance
Office of Athletics	$570.75
Total Annual Cost of Compliance for the Life of the Rule	**$570.75**

III. WORKSHEET

1. CALCULATION OF EXPENSE AND EQUIPMENT AND PERSONAL SERVICE COSTS:

The board anitipcates the staff will perform the following duties:

Licensure Technician II - Reviews application for completeness, updates division's licensing system, prepares and sends follow up letters, follows up with applicant for any additional information needed, responds to telephone inquiries, processes all documentation, prepares flow sheet for board review, prepares file for board review, updates divsion's licensing system after board review, and issues the license.

Clerk IV - Prepares decision letter for executive review and approval, prints seal application, prints wall hanging license, copies letter and wall hanging license for file, and mails licensure documentation to license.

Executive Director - Reviews file prior to board review and prepares and reviews decision letter.

Salaries for the staff are shared with other boards within the division. The figures below represent the personal service costs supported by the State Board of Chiropractic Examiners.

Employee's salaries were calculated using their annual salary multiplied by 40.77% for fringe benefits and then were divided by 2080 hours per year to determine the hourly salary. The hourly salary was then divided by 60 minutes to determine the cost per minute. The cost per minute was then multiplied by the amount of time individual staff spent on the processing of applications. The total cost was based on the cost per application multiplied by the estimated number of applications.

STAFF	ANNUAL SALARY	SALARY TO INCLUDE FRINGE BENEFIT	HOURLY SALARY	TIME PER APPLICATION	COST PER APPLICATION	TOTAL COST
Executive Director	$51,300	$72,215.01	$34.72	15 minutes	$8.68	$130.20
Clerk IV	$28,740	$40,457.30	$19.45	15 minutes	$4.86	$72.90
Licensure Technican II	$24,144	$33,987.51	$16.34	90 minutes	$24.51	$367.65

IV. ASSUMPTIONS

1. In the event inadequate information is submitted, it may be necessary for the board to review an application but it is not anticipated.
2. The board does not anticipate any growth in the number of applications received each year.
3. The total cost will recur for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee.

NOTE: The public fiscal note for this rule only reflects the cost for this particular process. However, private entity fees are set at an amount to cover the total actual cost incurred by the board, which includes personal service, expense and equipment and transfers.

PRIVATE ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development

Division 145 - Missouri Board of Geologist Registration

Chapter 2 - Licensure Requirements

Proposed Amendment - 4 CSR 40-4.090 Contestants

Prepared February 18, 2005 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Annual Cost

Estimate the number of entities by class which would likely be affected by the adoption of the proposed amendment:	Classification by type of the business entities which would likely be affected:	Estimated annual cost of compliance with the amendment by affected entities:
237	Contestant Applicants (Physical Examination @ $50)	$11,850
237	Contestant Applicants (Medical Tests @ $108)	$25,596
66	Female Contestant Applicants (Pregnancy Test @ $20)	$3,300
	Estimated Annual Cost of Compliance for the Life of the Rule	**$40,746**

Biennial Cost

Estimate the number of entities by class which would likely be affected by the adoption of the proposed amendment:	Classification by type of the business entities which would likely be affected:	Estimated biennial cost of compliance with the amendment by affected entities:
1,007	Contestants (Physical Examination @ $50)	$50,350
1,007	Contestants (Medical Tests @ $108)	$108,756
	Estimated Biennial Cost of Compliance for the Life of the Rule	**$108,756**

III. WORKSHEET

See table above.

IV. ASSUMPTION

1. The above figures were based on FY04 actuals and FY05 projections. The board estimates approximately 142 boxing, 1 marital arts and 94 wrestling applicants will apply for licensure annually. The board further estimates that approximately 633 wrestling, 8 marital arts, and 368 boxing contestants will apply for licensure renewal biennially.
2. The board does not anticipate any growth in the number of applications received each year.
3. It is anticipated that the total cost will recur annually for the life of the rule, may vary with inflation and is expected to increase annually at the rate projected by the Legislative Oversight Committee.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 40—Office of Athletics
Chapter 5—Inspector Duties and Rules for Professional Boxing, Professional Wrestling, Professional Kickboxing and Professional Full-Contact Karate

PROPOSED AMENDMENT

4 CSR 40-5.030 Rules for Professional Wrestling. The division is proposing to amend section (1), delete sections (2)–(4) and (6) and renumber the remaining sections appropriately.

PURPOSE: This rule is being amended as a result of the rescission and readoption of 4 CSR 40-4.090.

(1) *[All professional wrestling contests shall be subject to the laws and regulations governing professional wrestling.]* The promoter shall be liable for ensuring that all statutes and rules promulgated by the office are strictly observed and carried out, including using only licensed individuals at all contests.

[(2) A person may not be issued a license to wrestle by the office if s/he is under sixteen (16) years of age. An applicant for a license as a wrestler must be in writing on a form furnished by the office. Any person who gives incorrect information in an application for license as a wrestler may be disciplined by the office.

(A) A wrestler who is under the age of eighteen (18) years of age, must have a signed notarized affidavit from their legal guardian approving them to participate as a wrestling contestant.

(3) Any wrestler applying for a license or renewal first must be examined by a physician licensed with the designation of "medical doctor" or "doctor of osteopathy" to establish physical fitness. The office may order the examination of any wrestler at any time to determine whether the wrestler is fit and qualified to engage in further contests. The professional wrestler must successfully complete an annual physical examination by a physician of the wrestler's choice within thirty (30) days of application for initial licensure and within thirty (30) days of application for license renewal, the office may increase the thirty (30)-day limit under special circumstances approved by the office. A wrestler who has applied for a license to engage in professional wrestling, or a wrestler who has applied for renewal of his/her license must:

(A) Provide with his/her application an original or certified copy of the results of the following medical tests performed by a certified laboratory no earlier than one hundred eighty (180) days before the application is submitted, which shall:

1. Verify that the contestant is not infected with the human immunodeficiency virus (HIV); and

2. Verify that the contestant is not infected with the hepatitis B or C virus. The office may require a wrestler to submit to additional medical testing as deemed necessary.

(4) The office may require:

(A) A contestant to undergo a drug test. All fees involved with drug tests are the responsibility of the promoter or contestant. A positive reading may result in the suspension or discipline of a license.

(B) The promoter to have a licensed "medical doctor" or "doctor of osteopathy" and/or ambulance present at the contest, as deemed necessary.]

[(5)] **(2)** The referee and/or the office shall decide all questions arising out of a contest not specifically covered by the statutes and these rules. In all other respects, wrestling shall be subject to the statutes and rules governing this sport.

[(6) Wrestlers shall appear at the location of the event at least one (1) hour before the scheduled contest begins.]

[(7)] **(3)** Wrestler's Equipment.

(A) A wrestler shall be clothed in clean apparel.

(B) A wrestler may wear two (2) pair of trunks, one (1) over the other.

(C) If a wrestler wears shoes, they shall be fitted with soft tops, soft smooth soles, soft laces and equipped with eyelets only.

(D) A wrestler may not have any grease, lotion, or foreign substances on the body.

(E) A female wrestler must wear trunks and a top.

(F) The inspector present at the event may disallow the use of inappropriate attire or disqualify a wrestling participant for the lack of appropriate attire.

[(8)] **(4)** Contestants shall have their fingernails trimmed closely.

[(9)] **(5)** Ring Barrier.

(A) A ring shall be enclosed within a barrier which shall be erected between the ring and the seating area in the arena.

(B) The barrier shall be at least:

1. Six feet (6') away from the ring; and
2. Four feet (4') away from the first row of the seating area.

(C) The ring barrier shall conform to the following requirements:

1. Be constructed of metal or other shatterproof material;
2. Be designed to prevent a wrestler from exiting through the barrier into the seating area during a contest;
3. Be built to a height of at least forty-two inches (42") from the floor of the arena; and
4. Be stable.

(D) The ring barrier shall be approved by the office or the office's representative before its use during a contest.

[(10)] **(6)** Time Limits.

(A) A wrestling match shall have a maximum time limit of sixty (60) minutes.

(B) The office may authorize any other time limit.

[(11)] **(7)** A timekeeper shall begin the beginning of the time limit of a contest upon the referee's signal and shall sound the bell at the referee's command.

[(12)] **(8)** Conduct of Wrestling Contest.

(A) A wrestling contest shall be determined by:

1. One (1) fall; or
2. Two (2) out of three (3) falls.

[(13)] **(9)** Scoring a Fall.

(A) A fall is scored by a wrestler when the wrestler's opponent has both shoulders touching the mat for a count of three (3) seconds.

(B) The referee shall signal the wrestler scoring a fall by immediately slapping the mat.

[(14)] **(10)** Breaking.

(A) A wrestler:

1. Shall break a hold when instructed by the referee;
2. Failing to break upon instruction by the referee, the offending contestant shall be given a count of ten (10) to release the hold; and
3. Failing to release the hold after the count of ten (10), the offending contestant shall be disqualified and the opponent shall be awarded the match by the referee.

[(15)] **(11)** When any part of a contestant's body is touching the ropes or is outside the ropes or if, in the judgment of the referee, the contestant is no longer able to properly protect him/herself, the referee shall call time and the contestants at once shall release any holds and return to the center of the ring to standing positions and resume the bout.

[(16)] **(12)** Prohibited Activities.

(A) The following actions are prohibited:

1. Inhibiting breathing by covering the nose and mouth at the same time; and

2. Unsportsmanlike or physically dangerous conduct.

(B) A wrestler continuing to engage in prohibited activities after sufficient warning may be disqualified by the referee.

(C) No wrestling contestant shall use a foreign object(s) or prop(s) with the deliberate intent to lacerate himself or herself, or one's opponent. No animal blood or human blood, other than that of the wrestling contestants that is incidentally introduced during a match, may be used as a prop or special effect in any wrestling match. Vials, capsules or any vessel containing a gel substance appearing to be or simulating blood may be used as a prop or special effect during a wrestling contest so long as the container cannot cause lacerations upon breakage. The intent to use a foreign object(s) or prop(s) during a wrestling match must be disclosed to the office prior to any wrestling contest and shall be subject to the approval of the inspector present at the event. This shall include any vial, capsule or container holding a gel substance that is meant to simulate blood.

[(17)] **(13)** Refusal or Inability to Continue.

(A) If a wrestler refuses or is physically unable to continue a match, the match shall be ended and the decision awarded to the wrestler's opponent.

[(18)] **(14)** Tag Team Wrestling.

(A) "Tag Team Wrestling" means a contest between two (2) teams each composed of two (2) or more wrestlers.

(B) The time limit for this type of contest shall be a maximum of sixty (60) minutes.

(C) A team shall be awarded a fall when a member of the team scores a fall against a member of the opposing team.

(D) A two (2)-minute rest period may be permitted between falls.

(E) A tag team contest shall be conducted as follows:

1. The contest shall begin with one (1) wrestler from each team inside the ring while the respective partners remain outside the ring on the apron;

2. The wrestler(s) outside the ring may not enter the ring unless a fall is scored or his/her partner has tagged his/her hand;

3. In order to be eligible to receive a tag, the wrestler's partner shall be outside the ring on the apron in the proper corner with both feet on the ring apron and only receive the tag over the top ring rope;

4. When the tag is made, the wrestler making the tag shall leave the ring as the partner enters the ring;

5. Only two (2) wrestlers from opposing teams shall be permitted to be in the ring at any one (1) time;

6. After the scoring of a fall a wrestler may relieve the partner;

7. If a wrestler is unable to continue, the wrestler's partner shall continue the contest alone;

8. The referee may call time after an injury to permit the injured wrestler to be removed from the ring; and

9. Release the rope provided in the team corner until officially tagged by the partner.

[(19)] **(15)** The referee shall warn a team of any prohibited conduct and may disqualify a team for persisting in prohibited conduct after a warning.

[(20)] **(16)** A wrestler may have a second who:

(A) Shall remain in the wrestler's corner outside the ring enclosure; and

(B) The referee may immediately eject from the ring area any second engaging in prohibited activities after sufficient warning.

[(21)] **(17)** Referee.

(A) The referee shall have the authority to conduct the contest and enforce the regulations of the office;

(B) The referee's decision on any matter, whether arising under these regulations or not, shall be final; and

(C) Referees assigned to officiate a contest shall:

1. Be properly attired thirty (30) minutes before the scheduled time of the opening contest; and

2. Remain attired and available until all matches have been concluded.

[(22)] **(18)** Responsibility of Promoter.

(A) A promoter shall be responsible to the office for the conduct of its representatives and employees, including officials and contestants affiliated with the event.

(B) The promoter shall be responsible for conducting the wrestling contest in a safe, peaceable, and orderly fashion.

(C) Violation of the office's regulations by a representative or employee of the promoter, including officials and contestants affiliated with the event, may be grounds for disciplinary action against the promoter.

AUTHORITY: sections 317.006 and 317.015, RSMo 2000. Original rule filed April 30, 1982, effective Sept. 11, 1982. Rescinded and readopted: Filed March 2, 1989, effective May 11, 1989. Rescinded and readopted: Filed Nov. 15, 2001, effective May 30, 2002. Amended: Filed July 1, 2004, effective Oct. 30, 2004. Amended: Filed May 13, 2005.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of Athletics, PO Box 1335, Jefferson City, MO 65102, by facsimile at (573) 751-5649 or via e-mail at athletic@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 195—Division of Job Development and Training
Chapter 3—General Rules, Missouri Community College New Jobs Training Program

PROPOSED RESCISSION

4 CSR 195-3.010 New Jobs Training Program. This rule established guidelines for program coordination and project evaluation of the Missouri Community College New Jobs Training Program.

PURPOSE: This rule is being rescinded in order to be readopted (also under 4 CSR 195-3.010) to include updated language and fiscal information.

AUTHORITY: section 178.895, RSMo Supp. 1995. Original rule filed Dec. 16, 1988, effective April 27, 1989. Amended: Filed Oct.

16, 1990, effective March 14, 1991. Amended: Filed July 29, 1994, effective Feb. 26, 1995. Amended: Filed May 14, 1996, effective Dec. 30, 1996. Amended: Filed Nov. 1, 1996, effective May 30, 1997. Rescinded: Filed May 16, 2005.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Economic Development, Division of Workforce Development, Amy Deem, Assistant Director, 421 East Dunklin, PO Box 1087, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 195—Division of Workforce Development
Chapter 3—Missouri Bond-Funded Industry Training Programs

PROPOSED RULE

4 CSR 195-3.010 New Jobs Training Program

PURPOSE: The Department of Economic Development, Division of Workforce Development, has the responsibility to coordinate the Missouri Community College New Jobs Training Program, approve company eligibility, and evaluate the project within the overall job training efforts of the state to ensure that the project will not duplicate other job training programs. This rule establishes guidelines for program coordination and project evaluation.

(1) Administrative responsibilities for the Missouri Community College New Jobs Training Program shall be divided between the Division of Workforce Development (DWD), the Missouri Department of Revenue (DOR) and any Missouri community college district participating in the New Jobs Training Program.

(A) DWD shall review potential projects for nonduplication with known state and federally subsidized training programs.

1. A project will be considered as nonduplicative if subsidies from separate sources are not concurrently received to fund training for the same employee in the same training activity or cost as described in 4 CSR 195-3.010(4).

2. Separate training activities or costs for the same employee but subsidized by different sources shall not be considered as duplicative whether concurrent or not.

(B) DWD shall review potential projects for company eligibility in accordance with section 178.892, RSMo.

(C) DWD shall disburse monies from the Missouri Community College Job Training Program Fund pursuant to requirements stipulated in section 178.896, RSMo.

(D) DOR shall make deposits to the Missouri Community College Job Training Program Fund from the new jobs credit from withholding claims by employers participating in the Missouri Community College New Jobs Training Program.

(E) DOR shall notify DWD, on a monthly basis, of—

1. The total balance of the Missouri Community College Job Training Program Fund; and

2. The total contribution to that fund by, or on the behalf of, each participating employer, and the proportion of each employer's contribution to the total fund balance.

(F) DWD will generate a monthly report that tracks expenditures relative to the annual appropriation and provide this report, as well as information provided by DOR, to the community college districts.

(G) Any Missouri community college district participating in the Missouri Community College New Jobs Training Program shall bear responsibility for—

1. Determining of training eligibility for participation in the Missouri Community College New Jobs Training Program;

2. Monitoring each training project to ensure that funds are used in accordance with the training agreement;

3. Providing a quarterly report to be received by DWD no later than thirty (30) calendar days after the quarterly ending date. This report, for each new jobs training project, shall include the total amount of certificates sold, the total amount of certificates retired, and the remaining balance of outstanding certificates sold. If the total amount of the outstanding certificates sold by the community college districts nears the twenty (20) million dollar limit, DWD may request that the community college districts provide a report to DWD on a monthly basis.

4. Including an annual financial audit that contains each project's Missouri Community Colleges New Jobs Training Program Activities as part of the regular audit of the community college district. This responsibility shall include:

A. Review of the audit;

B. Resolution of any management findings and questioned and disallowed costs; and

C. A reasonable attempt to collect disallowed costs resulting therefrom;

5. Identifying any balances in the special funds and accounts for each project;

6. Notifying the employer, DWD and DOR when the new jobs credit from withholding has expired or when the certificate has been retired;

7. Submitting to DOR any excess funds in accordance with 4 CSR 195-3.010(21); and

8. Complying with all other requirements identified pursuant to sections 178.892–178.896, RSMo and 4 CSR 195-3.010.

(2) DWD bears no responsibility for any disallowed costs determined in the annual audit of the community college district or collection from it.

(3) The new jobs training program provides assistance to eligible new or expanding industries through training projects established by a Missouri community college district that will provide education and training of workers for new jobs, pursuant to requirements in sections 178.892–178.896, RSMo.

(A) A new industry is an employer who initiates production, research and development or service subsequent to, or one hundred eighty (180) days prior to, the date the notification of intent to submit a Missouri Community College New Jobs Training Program Application is received by DWD.

(B) A change of ownership of an industry currently operating within the state is not a new industry but is an expanding industry if new jobs are created.

(C) An expanding industry is an existing employer that creates new jobs.

(D) New jobs are those positions newly created by a new or expanding industry or employer as follows:

1. A new job is not a job intended to replace a current job;

2. A new job is not a job created to replace or supplant the job of an existing employee engaged in an authorized work stoppage; or

3. A new job includes a job that was created by the employer during a period of time that does not precede one hundred eighty (180) days prior to the date DWD receives a notification of intent to submit a Missouri Community College New Jobs Training Program Application from a community college district.

(E) The terms New Jobs Training Program and Missouri Community College Job Training Program are synonymous and interchangeable with the term Missouri Community College New Jobs Training Program.

(4) Assistance is available for all necessary and incidental costs of providing New Jobs Training Program services for new and existing employees directly affected by the expansion that may include, but are not limited to:

(A) New jobs training that allows employees in newly created jobs to acquire, refine and improve the level of their occupational skills in order to perform the requirements of their particular job in a more proficient and effective manner;

(B) Basic skills and job-related instructional costs, including wages and fringe benefits of instructors, who may or may not be employees of the industry or employer and training development costs, including the cost of training of instructors;

(C) Activities designed to assess the skills or aptitudes of individuals applying for employment in the newly created jobs designated to receive training assistance through the program;

(D) Training facilities;

(E) The cost of a facility used in training and subsequently used in production shall be prorated to the project in that proportion chargeable to the training program with the remaining facility cost being the responsibility of the industry or employer;

(F) Training Equipment.

1. Training equipment shall be leased, purchased, maintained and disposed of in accordance with established policies and procedures and training standards of the community college district.

2. The community college district shall retain inventory and disposition records of all training equipment purchased for a project.

3. The cost of equipment used in training and subsequently used in production shall be prorated to the project in that proportion chargeable to the training program with the remaining equipment cost being the responsibility of the industry or employer.

4. Title of that equipment shall be vested with the community college district until disposed of by the community college district;

(G) Training Materials and Supplies.

1. Training materials and supplies shall be defined and purchased in accordance with established policies and procedures and training standards of the community college district.

2. The cost of materials and supplies used in training which are subsequently used in production shall be prorated to the project in that proportion chargeable to the training program and the remainder of the cost of materials and supplies will be the responsibility of the industry or employer;

(H) On-the-Job Training (OJT).

1. OJT is on-site training provided to an employee engaged in productive work.

2. Payments for OJT will not exceed the average of fifty percent (50%) of the total wages paid to each participant during the training period. Payment for OJT may continue for up to six (6) months after the placement of the participant in the new job.

3. OJT payments for a new job may not be paid to an employer who is receiving other sources of funds to provide OJT for the same new job when the costs would result in the employer receiving more than fifty percent (50%) of the total wages for each OJT trainee during training.

4. The maximum amount of OJT cannot exceed fifty percent (50%) of the total training project;

(I) Administrative expenses or costs shall include:

1. All costs directly or indirectly associated with the supervision and administration of a training project and also directly associated with New Jobs Training Program activities of an individual community college district, including the negotiation of a training activities proposal with the employer, submission of the training activities proposal and required report, advertising, interviewing and selecting staff for a New Jobs Training Program project, procuring materials and service for a training project, direct clerical support to the training project, and mileage for the travel of administrative and supervisory project staff;

2. The dollar amount expended for administrative expenses or costs shall equal fifteen percent (15%) of the total training costs of a New Jobs Training Program project. Total training costs are the costs of training including:

A. Supplies;

B. Wages and benefits of instructors;

C. Subcontracted services;

D. OJT;

E. Training facilities;

F. Equipment;

G. Skill assessment; and

H. All program services, provided however, that no costs associated with the issuance of certificates shall be included.

(J) Contracted services with state institutions of higher education, private colleges or universities, area career technical schools, other federal, state or local agencies or other professional services shall be procured in the manner provided by the community college district board of trustees.

(K) Issuance of Certificates.

1. Financial institution shall include any bank acting in a fiduciary capacity, any broker/dealer of securities presently registered with the commissioner of securities or any discount bank brokerage service executing an unsolicited order.

2. Sales of certificates issued under these rules, which constitute securities, are subject to the provisions of Chapter 409, RSMo and the rules and orders promulgated under it; and

3. Nothing in these rules precludes reliance on the exemption from securities registration set forth in Chapter 409, RSMo and payment of the principal, of premium, if any, and interest on certificates, including capitalized interest issued to finance a project, and funding and maintenance of a debt service reserve fund to secure those certificates.

(5) The community college district will notify DWD and the Workforce Investment Board (WIB) of its intent to submit a Missouri Community College New Jobs Training Program Application with an eligible industry or employer. This notification will serve to avoid duplication of training and provide opportunity for economically disadvantaged citizens to pursue employment in newly created jobs.

(A) The notification is to be made in writing on forms approved by and available from DWD.

(B) The notification must include, but need not be limited to:

1. The employer's name, telephone number, location, the industry or employer Missouri Integrated Tax System Number and the industry or employer Unemployment Insurance Identification Number, unless these numbers have not yet been assigned to the employer;

2. The tentative dates that training will begin and end;

3. The occupational title and wage or salary for new jobs which will receive training, if known; and

4. The location of the training site(s), if known.

(C) Upon receipt of the notice of intent, DWD will forward a copy to the commissioner of administration.

(D) DWD will accept written comments from the WIB submitted as a result of the community college district's intent to submit a Missouri Community College New Jobs Training Program application, or any subsequent Missouri Community College New Jobs Training Program Application.

1. Comments must be received by DWD prior to approval of the Missouri Community College New Jobs Training Program application.

2. Comments should be restricted to areas relating to duplication with other job training programs that would be caused by the project proposed by the community college district.

(6) DWD will review the notice of intent and determine company eligibility in accordance with section 178.892, RSMo.

(7) The commissioner of administration shall notify DWD within five (5) working days of any concerns regarding the issuance of certificates.

(8) Within ten (10) working days of receipt of the notification, DWD will notify the community college district if DWD is aware of assistance being provided to the employer by other job training programs that are potentially duplicative of the project proposed by the community college district. DWD will also notify the community college district of company ineligibility.

(9) If, within ten (10) working days, the community college does not receive notification from DWD regarding potential duplication with other job training programs, development of the Missouri Community College New Jobs Training Program application may proceed.

(10) The community college district will submit the Missouri Community College New Jobs Training Program application for a project to DWD, the DOR and the WIB on forms approved by and available from DWD.

(A) The Missouri Community College New Jobs Training Program application for a project must be signed by an authorized representative(s) from the community college district and the employer.

(B) The Missouri Community College New Jobs Training Program application for a project must include, but need not be limited to:

1. Any changes in, or additions to, information required to be submitted in the notification of intent to submit a Missouri Community College New Jobs Training application;

2. A description of the new jobs training project, including a description of each type of training program service (basic skills assessment and testing, lease of facilities and equipment, training materials and supplies, on-the-job training, administrative costs and other training and services procured for the employer);

3. Estimated program costs, including deferred costs;

4. Costs of the training project;

5. Estimated costs to issue certificates, such as bond counsel, underwriter's discount, trustees fees, etc.;

6. The time period involved for the project;

7. A description of the intended choice of financing program costs, either new jobs credit from withholding, tuition, student fees or special charges fixed by the community college district board of trustees or a combination of these sources.

A. Descriptions of the funding sources shall be provided in a manner that is clearly identified by the estimated amount and funding source.

B. A separate description of the first one hundred (100) jobs, including job titles, that shall be a part of the training agreement; and

8. A description of any funds that the community college knows the industry or employer has received, is receiving or intends to utilize to subsidize the training required for the newly created jobs that are proposed to be included in the project.

(C) The community college district shall demonstrate how the proposed New Jobs Training Project will not duplicate other job training programs.

(D) Where a collective bargaining agreement exists with the employer for the jobs to be trained through the training agreement, the employer shall send through registered mail, a formal request to the appropriate bargaining agent for written comments on the proposed training project.

1. The request for written comments shall be made through registered mail and shall notify the bargaining agent that if no comments are received within fifteen (15) days, the employer will assume the bargaining agent agrees with the proposed training.

2. The employer shall allow the bargaining agent no fewer than fifteen (15) days to comment on the proposed training.

3. A copy of the request for written comments shall be attached to the Missouri Community College New Jobs Training Program application.

(E) Upon receipt of the application, DWD will forward a copy to the commissioner of administration.

(F) Any Missouri Community College New Jobs Training Program application for a project initiated and operated by one (1) community college district within the boundaries of another community college district or any training project operated by a community college district for an employer creating new jobs in another community college district will require written concurrence from the community college district board of trustees where training will occur or where the new jobs are being created.

(G) The Missouri Community College New Jobs Training Program application for a project shall not be considered complete or acceptable for evaluation until approved and required forms are received by DWD with all required statements completed.

(11) DWD shall evaluate the project which is the subject of the Missouri Community College New Jobs Training Program application to ensure that the project will not duplicate other job training programs.

(12) The commissioner of administration shall notify DWD within nine (9) working days of any concerns about a potential project regarding the issuance of certificates.

(13) Within fourteen (14) working days after receipt of the Missouri Community College New Jobs Training Program application, DWD will notify the community college district of any duplication with other job training programs, training concerns or concerns regarding the issuance of certificates. Upon receipt of notice of duplication with other job training programs, the community college district will modify the Missouri Community College New Jobs Training Program application to eliminate the duplicate job training efforts specified by DWD.

(A) The modified Missouri Community College New Jobs Training Program application shall be submitted to DWD using the procedures specified for submission of the original Missouri Community College New Jobs Training Program application.

(B) DWD shall follow the same procedures followed in review of an original Missouri Community College New Jobs Training Program application to review a modified Missouri Community College New Jobs Training Program application.

(14) Approval of the Missouri Community College New Jobs Training Program application allows the community college district and an employer to enter into an agreement provided there are no significant changes to the application submitted.

(15) The effective date of the training agreement shall be the date of, or subsequent to, the date DWD received notification of intent to submit a Missouri Community College New Jobs Training Program application from the community college district. Program costs can be incurred prior to the effective date of the training agreement but not prior to the effective date of the notice of intent.

(16) An agreement may be for a period not to exceed ten (10) years when the total cost of the project is not in excess of five hundred thousand dollars ($500,000). If the total cost of a project is in excess of five hundred thousand dollars ($500,000), the agreement may be for a period not to exceed eight (8) years.

(17) Upon entering into a training agreement, the community college district shall provide a copy of the agreement to DWD.

(18) During the life of the training agreement, the community college district shall notify DWD and DOR of significant changes in the new jobs training project within fifteen (15) working days of project modification.

(A) Significant changes in a new jobs training project include, but are not limited to:

1. The new jobs that are identified as the first one hundred (100) included in the project;

2. The new jobs credit from withholding required by changes in business or employment conditions; or

3. The type of training to be provided, project cost or any change which shall duplicate any funding being received to train an employee for jobs contained in the training agreement.

(B) Notification must be made with a narrative explanation of changes and a copy of the revised training agreement.

(19) The community college district shall deliver a report to DWD, no later than the first day of October each year, on assistance provided during the previous fiscal year through each new jobs training program agreement.

(20) Notification of Payments and Claims for Credit.

(A) Any taxpayer claiming the Missouri Community College New Jobs Training Credit must acquire, complete and attach Form MO-JTC, provided by DOR to his/her Employers Report of Income Taxes Withheld, Form MO-941, for the last withholding return filed for the reporting period.

(B) Any amount of New Jobs Training Credit which exceeds the amount of withholding tax due shall not be refunded but shall be carried forward and applied to withholding tax liability in subsequent periods.

(C) The New Jobs Training Credit claimed by qualifying employers shall be the sum of the following:

1. The gross wages attributable to the first one hundred (100) qualifying jobs of the job training project multiplied by two and one-half percent (2 1/2%); plus

2. The gross wages attributable to qualifying jobs of the job training project, in excess of the first one hundred (100) qualifying jobs, multiplied by one and one-half percent (1 1/2%); plus

3. Any unused job training credit left over from the previous filing period. That credit amount shall be computed on Form MO-JTC and remitted as withholding tax on Form MO-941.

(D) The DOR shall credit to the Missouri Community College Job Training Program Fund that amount of withholding tax computed by the employer on Form MO-JTC and paid by the employer on Form MO-941.

(21) Any balances held in the community colleges' special funds after all program costs for each project are paid shall be returned to DOR for inclusion in the general revenue fund.

(22) Community college districts shall notify the DOR and the Department of Economic Development within fifteen (15) days after it is determined that payments for job training will no longer be applied against the costs of a qualified project.

(23) The Department of Economic Development shall notify the Legislative Oversight Committee and the community college districts should the total amount of outstanding certificates sold by all community college districts exceed eighteen (18) million dollars. Should the total amount of outstanding certificates sold reach the twenty (20) million dollar limitation, DWD will notify the community college districts and subsequent notice of intents received by DWD will be processed in the order received.

AUTHORITY: section 178.895, RSMo 2000. Original rule filed Dec. 16, 1988, effective April 27, 1989. Amended: Filed Oct. 16, 1990, effective March 14, 1991. Amended: Filed July 29, 1994, effective Feb. 26, 1995. Amended: Filed May 14, 1996, effective Dec. 30, 1996. Amended: Filed Nov. 1, 1996, effective May 30, 1997. Rescinded and readopted: Filed May 16, 2005.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions seven thousand two hundred nineteen dollars ($7,219) annually in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Economic Development, Division of Workforce Development, Amy Deem, Assistant Director, 421 East Dunklin, PO Box 1087, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. RULE NUMBER

Rule Number and Name:	4 CSR 195-3.010 New Jobs Training Program
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Division of Workforce Development	$7,219

III. WORKSHEET

PERSONNEL	FTE	ANNUAL SALARY	SUPPLIES	OTHER	**TOTALS**
Asst. Director/Manager	0.05	$4,242	$0	$0	$4,242
WFD Spec. IV	0.05	$2,685	$0	$0	$2,685
WFD Spec. IV	0.03	$146	$0	$0	$146
WFD Spec. IV	0.03	$146	$0	$0	$146
TOTAL ANNUAL COSTS		**$7,219**	**$0**	**$0**	**$7,219**

IV. ASSUMPTIONS

Costs are based on a pro-rated application of the portion of time (salary, fringe, space, supply) of the affected four staff associated with the program.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 195—Division of Workforce Development
Chapter 3—Missouri Bond-Fund Industry Training Programs

PROPOSED RULE

4 CSR 195-3.020 Job Retention Training Program

PURPOSE: The Department of Economic Development, Division of Workforce Development, has the responsibility to coordinate the Missouri Community College Job Retention Training Program, approve company eligibility, and evaluate the project within the overall job training efforts of the state to ensure that the project will not duplicate other job training programs. This rule establishes guidelines for program coordination and project evaluation.

(1) Administrative responsibilities for the Missouri Community College Job Retention Training Program shall be divided between the Division of Workforce Development (DWD), the Missouri Department of Revenue (DOR), and any Missouri community college district participating in the Job Retention Training Program.

(A) DWD shall review potential projects for nonduplication with known state and federally subsidized training programs.

1. A project will be considered as nonduplicative if subsidies from separate sources are not concurrently received to fund training for the same employee in the same training activity or cost as described in 4 CSR 195-3.020(4).

2. Separate training activities or costs for the same employee but subsidized by different sources shall not be considered as duplicative whether concurrent or not.

(B) DWD shall review potential projects for company eligibility in accordance with sections 178.760–178.764, RSMo.

(C) DWD shall disburse monies from the Missouri Community College Job Retention Training Program Fund pursuant to requirements stipulated in sections 178.760–178.764, RSMo.

(D) DOR shall make deposits to the Missouri Community College Job Retention Training Program Fund from the retained jobs credit from withholding claims by employers participating in the Missouri Community College Job Retention Training Program.

(E) DOR shall notify DWD on a monthly basis of—

1. The total balance of the Missouri Community College Job Retention Training Program Fund; and

2. The total contribution to that fund by, or on behalf of, each participating employer, and the proportion of each employer's contribution to the total fund balance.

(F) DWD will generate a monthly report that tracks expenditures relative to the annual appropriation and provide this report, as well as information provided by DOR, to the community college districts.

(G) Any Missouri community college district participating in the Missouri Community College Job Retention Training Program shall bear the responsibility for—

1. Determining of training eligibility for participation in the Missouri Community College Job Retention Training Program;

2. Monitoring each training project to ensure funds are used in accordance with the training agreement;

3. Providing a quarterly report to be received by DWD no later than thirty (30) calendar days after the quarterly ending date. This report, for each job retention training project, shall include the total amount of certificates sold, the total amount of certificates retired, and the remaining balance of outstanding certificates sold. If the total amount of outstanding certificates sold by the community college districts nears the fifteen (15) million dollar limit, DWD may request that the community college districts provide a report to DWD on a monthly basis;

4. Including an annual financial audit that contains each project's Missouri Community College Job Retention Training Program Activities as part of a regular audit of the community college district. This responsibility shall include:

A. Review of the audit;

B. Resolution of any management findings and questioned and disallowed costs; and

C. A reasonable attempt to collect disallowed costs resulting therefrom;

5. Identifying any balances in the special funds and accounts for each project;

6. Notifying the employer, DWD and DOR when the retained jobs credit from withholding has expired or when the certificate has been retired;

7. Submitting to DOR any excess funds in accordance with 4 CSR 195-3.020(17); and

8. Complying with all other requirements identified pursuant to sections 178.760–178.764, RSMo and 4 CSR 195-3.020.

(2) DWD bears no responsibility for any disallowed costs determined in the annual audit of the community college district or collection from it.

(3) The job retention training program provides assistance to eligible industries through projects established by a Missouri community college district that will provide education and retraining of workers for existing jobs, pursuant to requirements in sections 178.760–178.764, RSMo. An existing job is not one that replaces or supplants another existing job where the employee is engaged in an authorized work stoppage.

(4) Assistance is available for all necessary and incidental costs of providing job retaining program services for existing employees that may include, but are not limited to:

(A) Job retention training that allows employees in existing jobs to acquire, refine and improve the level of their occupational skills in order to perform the requirements of their particular job in a more proficient and effective manner;

(B) Basic skills and job-related instructional costs, including wages and fringe benefits of instructors, who may or may not be employees of the industry or employer and training development costs, including the cost of training of instructors;

(C) Activities designed to assess the skills or aptitudes of individuals in existing jobs designated to receive training assistance through the program;

(D) Training facilities;

(E) The cost of a facility used in training and subsequently used in production shall be prorated to the project in that proportion chargeable to the training program with the remaining facility cost being the responsibility of the industry or employer;

(F) Training Equipment.

1. Training equipment shall be leased, purchased, maintained and disposed of in accordance with established policies and procedures and training standards of the community college district.

2. The community college district shall retain inventory and disposition records of all training equipment purchased for a project.

3. The cost of equipment used in training and subsequently used in production shall be prorated to that project in proportion chargeable to the training program with the remaining equipment cost being the responsibility of the industry or employer.

4. Title of that equipment shall be vested with the community college district until disposed of by the community college district;

(G) Training Materials and Supplies.

1. Training materials and supplies shall be defined and purchased in accordance with established policies and procedures and training standards of the community college district.

2. The cost of training materials and supplies used in training which are subsequently used in production shall be prorated to the project in that proportion chargeable to the training program and the remainder of the cost of materials and supplies will be the responsibility of the industry or employer;

(H) On-the-Job Training (OJT).

1. OJT is on-site training provided to an employee engaged in productive work.

2. Payments for OJT will not exceed the average of fifty percent (50%) of the total wages paid to each participant during the training period. Payment for OJT may continue for up to six (6) months.

3. OJT payments for a retained job may not be paid to an employer who is receiving other sources of funds to provide OJT for the same retained job when the costs would result in the employer receiving more than fifty percent (50%) of the total wages for each OJT trainee during training.

4. The maximum amount of OJT cannot exceed fifty percent (50%) of the total training project;

(I) Administrative expenses or costs shall include:

1. All costs directly or indirectly associated with the supervision and administration of a training project and also directly associated with Job Retention Training Program activities of an individual community college district, including the negotiation of a training activities proposal with the employer, submission of the training activities proposal and required report, advertising, interviewing and selecting staff for a Job Retention Training Program project, procuring materials and service for a training project, direct clerical support to the training project, and mileage for the travel of administrative and supervisory project staff;

2. Training project costs are the costs for training including:

A. Supplies;

B. Wages and benefits of instructors;

C. Subcontracted services;

D. OJT;

E. Training facilities;

F. Equipment;

G. Skill assessment; and

H. All program services, provided however, that no costs associated with the issuance of certificates shall be included.

(J) Contracted services with state institutions of higher education, private colleges or universities, area career technical schools, other federal, state or local agencies or other professional services shall be procured in the manner provided by the community college district board of trustees.

(K) Issuance of Certificates.

1. Financial institution shall include any bank acting in a fiduciary capacity, any broker/dealer of securities presently registered with the commissioner of securities or any discount bank brokerage service executing an unsolicited order.

2. Sales of certificates issued under these rules, which constitute securities, are subject to the provisions of Chapter 409, RSMo and the rules and orders promulgated under it; and

3. Nothing in these rules precludes reliance on the exemption from securities registration set forth in Chapter 409, RSMo and payment of the principal, of premium, if any, and interest on certificates, including capitalized interest issued to finance a project, and funding and maintenance of debt service reserve fund to secure those certificates.

(5) The community college district will notify DWD in writing of its intent to submit a Missouri Community College Job Retention Training Program application with an eligible industry or employer prior to the submission of an official application. DWD shall provide a written response to the community college district the notification has been received.

(6) The community college district will submit the Missouri Community College Job Retention Program application for a project to DWD, the DOR, and the Workforce Investment Board (WIB) on forms approved by and available from DWD.

(A) The Missouri Community College Job Retention Training Program application for a project must be signed by an authorized representative(s) from the community college district and the employer.

(B) The Missouri Community College Job Retention Training Program application for a project must include, but need not be limited to:

1. The employer's name, telephone number, location, the industry or employer Missouri Integrated Tax System Number, and the industry or employer Unemployment Insurance Identification Number;

2. The dates that training will begin and end;

3. The occupational title and wage or salary for the retained jobs which will receive training;

4. The location of the training site;

5. A description of the job retention training project, including a description of each type of training program service (basic skills, assessment and testing, lease of facilities and equipment, training materials and supplies, on-the-job training, administrative costs and other training and services procured for the employer);

6. Program costs, including deferred costs;

7. Cost of the training project;

8. Costs to issue certificates, such as bond counsel, underwriter's discount, trustees fees, etc.;

9. The time period involved for the project;

10. A description of the intended choice of financing program costs, either job retention credit from withholding, tuition, student fees or special charges fixed by the community college district board of trustees or a combination of these sources.

A. Descriptions of the funding sources shall be provided in a manner that is clearly identified by the estimated amount and funding source.

B. A separate description of the first one hundred (100) jobs, including jobs titles, that shall be a part of the training agreement; and

11. A description of any funds that the community college knows the industry or employer has received, is receiving or intends to utilize to subsidize the training required for the retained jobs that are proposed to be included in the project.

(C) The community college district shall demonstrate how the proposed job retention project will not duplicate other job training programs.

(D) Where a collective bargaining agreement exists with the employer for the jobs to be trained through the training agreement, the employer shall send through registered mail, a formal request to the appropriate bargaining agent for written comments on the proposed training project.

1. The request for written comments shall be made through registered mail and shall notify the bargaining agent that if no comments are received within fifteen (15) days, the employer will assume the bargaining agent agrees with the proposed training.

2. The employer shall allow the bargaining agent no fewer than fifteen (15) days to comment on the proposed training.

3. A copy of the request for written comments shall be attached to the Missouri Community College Job Retention Training Program application.

(E) Upon receipt of the application, DWD will forward a copy to the commissioner of administration.

(F) Any Missouri Community College Job Retention Training Program application for a project initiated and operated by one (1) community college district within the boundaries of another community college district or any training project operated by a community college district for an employer retaining jobs in another community college district, will require written concurrence from the community college district board of trustees where training will occur or where the jobs are being retained.

(G) The Missouri Community College Job Retention Training Program application for a project shall not be considered complete or acceptable for evaluation until approved and required forms are received by DWD with all required statements completed.

(7) DWD shall evaluate the project which is the subject of the Missouri Community College Job Retention Training Program application to ensure that the project will not duplicate other job training programs.

(8) The commissioner of administration shall notify DWD within nine (9) working days of any concerns about a potential project regarding the issuance of certificates.

(9) Within fourteen (14) working days after receipt of the Missouri Community College Job Retention Training Program application, DWD will notify the community college district of any duplication with other job training programs, training concerns or concerns regarding the issuance of certificates. Upon receipt of notice of duplication with other job training programs, the community college district will modify the Missouri Community College Job Retention Training Program application to eliminate the duplicate job training efforts specified by DWD.

(A) The modified Missouri Community College Job Retention Training Program application shall be submitted to DWD using the procedures specified for submission of the original Missouri Community College Job Retention Training Program application.

(B) DWD shall follow the same procedures followed in review of an original Missouri Community College Job Retention Training Program application to review a modified Missouri Community College Job Retention Training Program application.

(10) Approval of the Missouri Community College Job Retention Training Program application allows the community college district and an employer to enter into an agreement provided there are no significant changes to the application submitted.

(11) The effective date of the training agreement shall be the date of, or subsequent to, the date DWD received the college's written intent to submit a Job Retention Training Program application from the community college district. Program costs can be incurred prior to the effective date of the training agreement but not prior to the effective date of the college's written intent.

(12) An agreement may be for a period not to exceed ten (10) years when the total cost of the project is not in excess of five hundred thousand dollars ($500,000). If the total cost of a project is in excess of five hundred thousand dollars ($500,000), the agreement may be for a period not to exceed eight (8) years.

(13) Upon entering into a training agreement, the community college district shall provide a copy of the agreement to DWD.

(14) During the life of the training agreement, the community college district shall notify DWD and DOR of significant changes in the job retention training project within fifteen (15) working days of project modification.

(A) Significant changes in a job retention training project include but are not limited to:

1. The retained jobs that are identified as the first hundred (100) included in the project;

2. The retained jobs credit from withholding required by changes in business or employment conditions; or

3. The type of training to be provided, project cost or any change which shall duplicate any funding being received to train an employee for jobs contained in the training agreement.

(B) Notification must be made with a narrative explanation of changes and a copy of the revised training agreement.

(15) The community college district shall deliver a report to DWD, no later than the first day of October each year, on assistance provided during the previous fiscal year through each job retention training project.

(16) Notification of Payments and Claims for Credit.

(A) Any taxpayer claiming the Missouri Community College Job Retention Training Program Credit must acquire, complete, and attach Form MO-RJC, provided by DOR to his/her Employers Report of Income Taxes Withheld, Form MO-941, for the last withholding return filed for the reporting period.

(B) Any amount of Job Retention Training Credit which exceeds the amount of withholding tax due shall not be refunded but shall be carried forward and applied to withholding tax liability in subsequent periods.

(C) The Job Retention Training Credit claimed by qualifying employers shall be the sum of the following:

1. The gross wages attributable to the first one hundred (100) qualifying jobs of the job training project multiplied by two and one-half percent (2 1/2%); plus

2. The gross wages attributable to qualifying jobs of the job training project, in excess of the first one hundred (100) qualifying jobs, multiplied by one and one-half percent (1 1/2%); plus

3. Any unused job training credit left over from the previous filing period. That credit amount shall be computed on Form MO-RJC and remitted as withholding tax on Form MO-941.

(D) The DOR shall credit to the Missouri Community College Job Retention Training Program Fund that amount of withholding tax computed by the employer on Form MO-RJC and paid by the employer on Form MO-941.

(17) Any balances held in the community colleges' special funds after all program costs for each project are paid shall be returned to DOR for inclusion in the general revenue fund.

(18) Community college districts shall notify the DOR and the Department of Economic Development within fifteen (15) days after it is determined that payments for job training will no longer be applied against the costs of a qualified project.

(19) The Department of Economic Development shall notify the Legislative Oversight Committee and the community college districts should the total amount of certificates sold by all community college districts exceed thirteen (13) million dollars. Should the total amount of outstanding certificates sold reach the fifteen (15) million dollar limitation, DWD will notify the community college districts and subsequent applications received by DWD will be processed in the order received.

AUTHORITY: section 178.763, RSMo Supp. 2004. Original rule filed May 16, 2005.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions seven thousand two hundred nineteen dollars ($7,219) annually in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Economic Development, Division of Workforce Development, Amy Deem, Assistant Director, 421 East Dunklin, PO Box 1087, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. RULE NUMBER

Rule Number and Name:	4 CSR 195-3.020 Job Retention Training Program
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Division of Workforce Development	$7,219

III. WORKSHEET

PERSONNEL	FTE	ANNUAL SALARY	SUPPLIES	OTHER	**TOTALS**
Asst. Director/Manager	0.05	$4,242	$0	$0	$4,242
WFD Spec. IV	0.05	$2,685	$0	$0	$2,685
WFD Spec. IV	0.03	$146	$0	$0	$146
WFD Spec. IV	0.03	$146	$0	$0	$146
TOTAL ANNUAL SALARIES		**$7,219**	**$0**	**$0**	**$7,219**

IV. ASSUMPTIONS

Costs are based on a pro-rated application of the portion of time (salary, fringe, space, supply) of the affected five staff associated with the program.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 2—Practice and Procedure

PROPOSED RULE

4 CSR 240-2.071 Expedited Small Complaint Procedure

PURPOSE: This rule establishes a simplified procedure for the processing of customer complaints against utilities.

(1) This rule applies only to complaints against companies regulated by the Missouri Public Service Commission made by customers who receive or are seeking to receive service in Missouri. Individuals may use this procedure without an attorney when complaining about their own service, and are not bound by the rules concerning the form of pleading found elsewhere in this chapter.

(2) To begin the process, make a written complaint that contains the following information:

(A) The name, address, telephone number and e-mail address of the person filing the complaint (the complainant), and the best way of contacting that person;

(B) The address at which the service was received or refused;

(C) The name of the company that provided or refused to provide the service (including the contact person familiar with the matter, if there is one);

(D) A description of the complaint matter. To the extent possible, include any available details, including names, dates, telephone numbers, copies of correspondence, copies of bills, or any other information that may be helpful in understanding what happened;

(E) A statement of the outcome you are seeking from the commission; and

(F) The signature of the person filing the complaint.

(3) The complaint must be sent to:

Secretary of the Commission
PO Box 360
Jefferson City, MO 65102-0360

(4) When the complaint is received at the commission, the following will happen:

(A) A copy of the complaint will be sent to the company, and the company will have thirty (30) days to send an answer to the commission that admits or denies the matters in the complaint, and sets out any defenses the company has to the complaint;

(B) The matter will be assigned to a regulatory law judge and set for a hearing. The complainant or the company may request to appear at the hearing by telephone, instead of in person;

(C) The judge will notify the complainant and the company of the hearing date and require the parties to send such information as the judge may need, including a list of any witnesses either party may call or any other documents or information, and may set a deadline by which the information must be provided; and

(D) The judge will provide the Office of the Public Counsel and the commission technical staff with copies of the complaint and will notify them of the hearing. They may conduct a neutral investigation of the matter and present their findings at the hearing.

(5) After the conclusion of the hearing, the judge will give the parties a written decision. That decision will be mailed to the complainant and the company. If either of those parties believes the decision is wrong, then that party must request a rehearing within ten (10) days of the date of the judge's decision. A request for rehearing must set out the reasons why the decision is wrong or unlawful, and must be received at the commission no later than ten (10) days from the date of the decision.

AUTHORITY: sections 386.040 and 386.410, RSMo 2000. Original rule filed May 5, 2005.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Public Service Commission, Dale Hardy Roberts, Secretary, PO Box 360, Jefferson City, MO 65102. To be considered, comments must be received no later than thirty (30) days after publication of this notice in the **Missouri Register**. Comments should refer to Case No. AX-2005-0364 and be filed with an original and six (6) copies. Comments may also be submitted using the commission's Electronic Filing and Information System at http://www.psc.mo.gov/efis.asp. A public hearing regarding this proposed rule is scheduled for July 19, 2005, at 10:00 a.m., in Room 310 of the Governor Office Building, 200 Madison Street, Jefferson City, Missouri. Interested persons may appear at this hearing to submit additional comments or testimony in support of or in opposition to this proposed rule, and may be asked to respond to commission questions. Any person who needs specific accessibility accommodations may call the Public Service Commission's Hotline at 1-800-392-4211 (voice) or Relay Missouri at 711 prior to the hearing.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 1—Organization

PROPOSED RULE

10 CSR 10-1.030 Air Conservation Commission Appeals and Requests for Hearings

PURPOSE: This rule contains all procedural regulations for all contested cases heard by the commission or assigned to a hearing officer by the commission.

(1) Subject. This rule contains all procedural regulations for all contested cases heard by the commission or assigned to a hearing officer by the commission.

(2) Definitions. As used in this rule, the following terms mean:

(A) Commission—The Missouri Air Conservation Commission;

(B) Department—The Department of Natural Resources, which includes the director thereof, or the person or division or program within the department delegated the authority to render the decision, order, determination, finding, or other action that is the subject of an initial pleading before the commission;

(C) Hearing—Any presentation to, or consideration by, the commission or hearing officer of evidence or argument on an initial pleading, motion or application;

(D) Hearing officer—The person or agency appointed by the commission to manage all delegated proceedings relating to the case;

(E) Initial pleading—A written appeal, request for hearing, or other document that initiates a contested case. An initial pleading shall be deemed to include subsequent amendments allowed by the presiding officer;

(F) Person—An individual, partnership, copartnership, firm, company, public or private corporation, association, joint stock company, trust, estate, political subdivision or any agency, board, department or bureau of the state or federal government or any other legal

entity whatever, which is recognized by law as the subject of rights and duties;

(G) Petitioner—The party filing the initial pleading;

(H) Presiding officer—The hearing officer for proceedings delegated by the commission, or the commission for proceedings not delegated to a hearing officer;

(I) Respondent—The department and any person later joined as respondent;

(J) Stay—A suspension of any action from which petitioner is seeking relief pending the final determination in the case.

(3) Appointment of Hearing Officers.

(A) As authorized by statute, in lieu of presiding over a hearing directly, the commission may select any of the following persons to preside over the hearing of an initial pleading—

1. Any one (1) or several members of the commission;

2. The Missouri Administrative Hearing Commission; or

3. An attorney qualified to practice in Missouri.

(B) The appointment, as authorized by statute and approved by the commission either as a general practice or on a case-by-case basis, may be made as follows:

1. By the chairman of the commission within the chairman's discretion;

2. By a vote of the majority of the commission; or

3. By the parties from a list of available hearing officers either by consensus or, when practical, by process of elimination that allows the parties, first the department and then the petitioner, an equal opportunity to strike names.

(4) Role of the Hearing Officer.

(A) Upon appointment, the department shall provide the hearing officer a letter confirming the appointment and copies of—

1. The initial pleading;

2. The written decision, order, determination, finding, or other action that is the subject of the initial pleading. This rule may be satisfied by providing a copy of the specific portion or portions of the action, such as a permit, that is contested;

3. Any entry of appearance by an attorney representing a party and any answer already filed with the commission; and

4. The names, addresses, phone and fax numbers of the parties or their attorneys, if this information is not already included in the above documents.

(B) The hearing officer has full authority to make rulings or issue orders on all matters that may arise except that the hearing officer shall not have the authority to render a final disposition on either jurisdictional grounds or the merits of a case that is not settled by the parties or voluntarily dismissed by the petitioner.

(C) For purposes of determining the final disposition of a cause on the basis of either the merits or the commission's jurisdiction, the hearing officer shall prepare a recommended decision, in writing, including findings of fact, conclusions of law, and a determination as to relief, for the commission's consideration. The hearing officer shall return the recommendation and the complete record of the proceedings in the cause to the commission.

(D) Upon receipt of the hearing officer's recommendation and the record in the case, the commission shall—

1. Distribute the hearing officer's recommendation to the parties or their counsel;

2. Allow the parties or their counsel an opportunity to submit written arguments regarding the recommendation;

3. Allow the parties or their counsel an opportunity to present oral arguments before the commission makes the final determination;

4. Complete its review of the record and deliberations as soon as practicable; the commission members may confer with the hearing officer during deliberations;

5. Deliberate and vote upon a final, written determination during an open meeting; and

6. Issue its final, written determination as soon as practicable.

(5) Computation of Time.

(A) In computing any period of time prescribed or allowed by this rule or by order of the presiding officer, the day of the act, event or default after which the designated period of time begins to run is not to be included. The last day of the period so computed is to be included, unless it is a Saturday, Sunday or legal holiday, in which event the period runs until the end of the next day that is neither a Saturday, Sunday nor legal holiday.

(B) Except for any period of time that establishes the commission's jurisdiction, the presiding officer may extend the time set by this rule either before or after the time period has expired.

(C) A party may move for an extension of the time set by this rule or by the presiding officer. The motion shall be in writing and shall state whether any party objects to the extension or that efforts to contact the parties have been futile.

(6) Practice by a Licensed Attorney; When Required.

(A) Any individual may present that individual's own case without a licensed attorney.

(B) Any individual may file an initial pleading on behalf of another person.

(C) Except as set forth in subsection (6)(B) of this rule, only a licensed attorney may represent any other person, including a corporation or other legal entity. The filing of any document with the presiding officer by a licensed attorney shall be deemed an entry of appearance. An attorney not authorized to practice in Missouri shall enter an appearance in accordance with Missouri Supreme Court Rules.

(7) Notice of Initiation of the Case.

(A) The department shall promptly mail a notice of institution of the case to all necessary parties, if any, and to all persons designated by the moving party and to any other persons to whom the department may determine that notice should be given. The department shall keep a permanent record of the persons to whom such notice was sent and of the addresses to which sent and the time when sent. Where a case would affect the rights, privileges or duties of a large number of persons whose interests are sufficiently similar that they may be considered as a class, notice may in a proper case be given to a reasonable number thereof as representatives of such class. In any case where the name or address of any proper or designated party or person is not known to the agency, and where notice by publication is permitted by law, then notice by publication may be given in accordance with any rule or regulation of the agency or if there is no such rule or regulation, then, in a proper case, the agency may by a special order fix the time and manner of such publication.

(B) The notice of institution of the case to be mailed as provided in this section shall state in substance:

1. The caption and number of the case;

2. That a writing seeking relief has been filed in such case, the date it was filed, and the name of the party filing the same;

3. A brief statement of the matter involved in the case unless a copy of the writing accompanies said notice;

4. Whether an answer to the writing is required, and if so the date when it must be filed;

5. That a copy of the writing may be obtained from the department, giving the address to which application for such a copy may be made. This may be omitted if the notice is accompanied by a copy of such writing; and

6. The location in the *Code of State Regulations* of the rules of the commission regarding discovery or a statement that the department shall send a copy of such rules on request.

(C) Unless the notice of hearing hereinafter provided for shall have been included in the notice of institution of the case, the agency shall, as promptly as possible after the time and place of hearing have been determined, mail a notice of hearing to the moving party and to all persons and parties to whom a notice of institution of the case was required to be or was mailed, and also to any other persons who may

thereafter have become or have been made parties to the proceeding. The notice of hearing shall state:

1. The caption and number of the case; and

2. The time and place of hearing.

(D) No hearing in a contested case shall be had, except by consent, until a notice of hearing shall have been given substantially as provided in this section, and such notice shall in every case be given a reasonable time before the hearing. Such reasonable time shall be at least ten (10) days except in cases where the public morals, health, safety or interest may make a shorter time reasonable; provided that when a longer time than ten (10) days is prescribed by statute, no time shorter than that so prescribed shall be deemed reasonable.

(8) Service of Filings Other Than the Initial Pleading.

(A) Unless otherwise provided by these rules or by other law, any party to a proceeding before the commission or any person who seeks to become a party shall serve upon the presiding officer and all attorneys of record and unrepresented parties a copy of any document or item the party files.

(B) Methods of Service.

1. A person may serve a document on an attorney by—

A. Delivering it to the attorney;

B. Leaving it at the attorney's office with a secretary, clerk or attorney associated with or employed by the attorney served;

C. Mailing it to the attorney's last known address; or

D. Facsimile transmitting (faxing) it to the attorney's last known fax number.

2. A person may serve a document on an unrepresented party by—

A. Delivering it to the party;

B. Mailing it to the party's last known address; or

C. Faxing it to the party's last known fax number.

(C) Service by mailing is complete upon placing in the mail. Service by fax is complete upon its transmission.

(D) Any document or item filed shall contain or be accompanied by a certification of how and when the filing party has met the provisions of this section.

(E) The presiding officer, after due notice, may waive the requirements of this section either on its own motion or on the motion of any party.

(F) The requirements of this section shall not apply to an initial pleading.

(9) Filing of Documents; Fax Filing.

(A) A party shall file a document with the presiding officer at the presiding officer's principle business office. Filings may be accomplished by—

1. Registered or certified mail. A document filed by registered or certified mail is deemed filed on the date shown on the United States Post Office records;

2. Electronic facsimile transmission (fax). A document filed by fax is deemed filed at the time the presiding officer receives a fax of the document. If a document arrives by fax after 5:00 p.m. and before 12:00 midnight or on a Saturday, Sunday or legal holiday, it is filed on the presiding officer's next business day, unless the presiding officer orders otherwise;

3. Actual delivery of a hard copy; or

4. Any other means as authorized by the Missouri Rules of Civil Procedure.

(B) A party filing by fax shall—

1. Notify the presiding officer in advance, if possible, of its intention to file the document by fax;

2. Fax the document to the presiding officer's dedicated fax number;

3. Fax the document, if possible, to all other parties having electronic facsimile equipment. If unable to fax, a party shall notify all other parties of its intention to file the document by fax. The notice need not be in writing. A good faith attempt at compliance shall satisfy the requirements of this subsection;

4. Send the original signed document to the presiding officer as the presiding officer so orders;

5. Certify in the documents—

A. The method of notice used to fulfill the requirements of paragraph (9)(B)3. of this rule; and

B. Compliance with the requirements of paragraph (9)(B)4. of this rule; and

6. Send a copy of the document to all parties. The presiding officer may order the party to send a copy of the document to any party by overnight mail.

(10) Stays.

(A) Scope and Content. The presiding officer may stay or suspend any action of the department pending the commission's findings and determination in the case. The presiding officer may require a bond or impose other conditions.

1. All motions for stay of the action from which petitioner is appealing shall be in writing.

2. The movant shall include in the motion:

A. The full name, address and telephone number of movant, any attorney representing movant and the respondent;

B. A clear heading, Motion for Stay;

C. Facts showing why the commission should grant the stay, set forth in numbered paragraphs, each of which shall contain, as far as practical, a single set of circumstances; and

D. A copy of any written notice of the action from which the petitioner is appealing.

3. The movant or movant's legal counsel shall sign the motion.

(B) The movant shall file the original and one (1) copy of the motion for stay with the presiding officer.

(C) The presiding officer, upon either party's request, shall hold or, on its own initiative, may hold an evidentiary hearing on whether to issue or dissolve a stay order.

(D) The denial of a motion for stay shall not prejudice the movant's initial pleading on the merits.

(E) The stay order shall remain effective until the commission finally disposes of the case unless the commission orders otherwise.

(11) Form of Initial Pleadings.

(A) In General. An initial pleading shall be in writing and shall include:

1. The full name, address and telephone number of—

A. Petitioner; and

B. Any attorney representing petitioner; and

2. An explanation of the relief sought and the reason for requesting it. The presiding officer shall construe the provisions of this section liberally. The presiding officer shall have the discretion to order the petitioner to amend the initial pleading by providing more detailed information regarding the relief sought and the basis for that relief before allowing the matter to proceed.

(B) Petitioner or petitioner's legal counsel shall sign the initial pleading.

(C) The initial pleading is deemed filed the day it is received by the commission.

(12) Answers.

(A) The respondent shall file an answer.

(B) An answer shall—

1. Be in writing;

2. Admit those portions of the initial pleading which the respondent believes are true and deny those portions that the respondent believes are not true and state that the respondent is without sufficient knowledge to admit or deny the portions not admitted or denied;

3. Assert any specific failure of the initial pleading to comply with this rule, or any other defenses; and

4. Be signed by the respondent or the respondent's attorney.

(C) The respondent shall file the answer within thirty (30) days after service of the notice of initial pleading.

(13) Intervention.

(A) The presiding officer shall follow Rule 52.12 of the Missouri Rules of Civil Procedure in determining any motion to intervene.

(B) A motion to intervene shall—

1. Be in writing;
2. Set forth facts showing that the person is entitled to intervene;
3. Be signed by the person or the person's attorney; and
4. Be accompanied by an initial pleading or answer.

(14) Discovery.

(A) Any party may conduct discovery in the manner provided for in the Rules of Civil Procedure adopted by the Supreme Court of Missouri.

(B) Written Interrogatories; Production of Documents or Things or Permission to Enter Upon Land or Other Property, for Inspection and Other Purposes.

1. A party serving written interrogatories; production of documents or things or permission to enter upon land or other property, for inspection and other purposes, shall include a certificate of service in substantially the following form:

I served the original and (*number of*) copies of these (*written interrogatories/ production of documents or things or permission to enter upon land or other property, for inspection and other purposes, requests for admission)* on (*name of parties*) this _____ day of _____, 20_____.

(*Signature*)_____

2. The party conducting discovery shall file a copy of the certificate with the presiding officer. The party shall not file written interrogatories; production of documents or things or permission to enter upon land or other property, for inspection and other purposes with the presiding officer unless the presiding officer so orders. The party may file requests for admissions with the presiding officer.

3. The party conducting discovery shall serve the original discovery on the interrogated party's counsel or on an unrepresented interrogated party, and copies on all other counsel or unrepresented parties.

4. Requests for admission and interrogatories shall include appropriate spaces for answers or objections.

5. The party responding to requests for admissions or interrogatories shall complete them by typewriting or printing the answer or objection to each question in the space provided. If the space is insufficient, the party shall reply by affidavit, clearly indicate so in the space provided, and attach the affidavit to the interrogatories or requests for admissions. Each response shall include a certificate of service in substantially the following form:

I served the original of these completed (*written interrogatories/requests for admission*) on (*name of party*) and sent (*number of*) copies to (*name of parties*) this _____ day of _____, 20_____.

(*Signature*)_____

6. The responding party shall file the certificate of service with the presiding officer and shall not file the response unless the presiding officer so orders. The responding party shall serve the original completed response on the interrogating party and copies on all other parties.

(C) Whenever a party files a motion to compel compliance with any discovery request, to sanction another party for failing to respond or responding inadequately to any discovery request, or alleging violation of any discovery rule, the moving party shall certify in its motion that it has made reasonable efforts to contact the party who is the subject of the motion and inform the presiding officer as to what steps the moving party has taken to resolve informally the discovery dispute or alleged discovery rule violation. The party seeking relief shall attach a copy of any disputed discovery to the motion to compel.

(D) No discovery or response to discovery shall be considered as evidence unless it is admitted into evidence upon hearing, or authenticated and attached to a motion for disposition without hearing, as an exhibit.

(E) No discovery order that permits entrance upon land or inspection of property without permission of the owner, or purports to hold any person in contempt shall be enforceable, unless the party seeking such enforcement obtains an order of the circuit court of the county in which the land or property is located, or the circuit court of Cole County, at the option of the person seeking enforcement.

(15) Sanctions.

(A) The presiding officer may impose a sanction upon any party for conduct including, without limitation, such party's failure to:

1. Comply with any rule of the commission or order of the presiding officer, including failure to file an answer;
2. Appear at any hearing; or
3. Apprise the presiding officer of a current mailing address.

(B) Sanctions available under this rule include without limitation:

1. Striking all or any part of the party's pleading;
2. Deeming all or any part of an opposing party's pleading admitted; or
3. Barring or striking all or any evidence on any issue.

(C) The presiding officer shall determine whether to impose any sanction, and the appropriate degree of such sanction, based on the facts of each case.

(16) Disposing of a Case Without a Hearing.

(A) Settlement. The parties may settle all or any part of the case without any action by the commission or by requesting agreed upon action by the commission, where such settlement is permitted by law. If the parties settle all of the case, petitioner shall file a notice of dismissal as described in subsection (16)(B) of this rule or a request for stipulated action by the commission.

(B) Notice of Dismissal. Petitioner may voluntarily dismiss the initial pleading at any time. Petitioner shall effect a voluntary dismissal by filing a notice of dismissal and is effective on the date petitioner files it, without any action by the commission.

(C) The commission may grant a motion for decision without hearing if the parties stipulate to undisputed facts and the commission determines that such facts entitle any party, including a party who did not file such motion, to a favorable decision on all or any part of the case as a matter of law.

(D) Involuntary Dismissal. Involuntary dismissal means a disposition of the case that does not reach the merits of the complaint. Grounds for involuntary dismissal of the complaint include without limitation:

1. Lack of jurisdiction; and
2. The bases for a sanction set forth in this rule.

(17) Prehearing Conferences. On its own motion or that of any party, the presiding officer may order a prehearing conference to discuss matters pertinent to the case. All parties or their legal counsels, or both shall participate in the prehearing conference and be prepared to discuss the matters, including the possibilities for settlement.

(18) Hearings on Motions. The presiding officer may rule upon any motion on the basis of the record and without oral argument. The presiding officer shall hear oral argument or evidence only upon a party's written motion or upon the presiding officer's own motion.

(19) Hearings; Default.

(A) Notice. The hearing officer shall serve an initial notice of hearing on all parties or their counsel by regular mail. The notice of hearing shall state the date, time and place of the hearing and shall be served at least ten (10) days prior to the hearing. The presiding officer may serve any other notice of hearing by any other method allowed by law.

(B) Location. The hearing officer shall hold all hearings in Jefferson City, Missouri, except as otherwise provided by statute or when a party shows good cause to hold the hearing elsewhere within the state.

(C) Date.

1. First setting. Unless otherwise provided by statute or with the consent of the parties, the hearing officer shall not conduct any hearing on less than ten (10) days notice.

2. Resettings. The hearing officer may reset the hearing by amended notice. If the reset date is later than the first setting, the hearing officer may hold the hearing fewer than ten (10) days from the date of the issuance of the amended notice.

(D) Expedited Hearings and Continuances. The hearing officer may expedite or continue the hearing date upon notice to the parties except as otherwise provided by law. Any party may file a motion for an expedited hearing or a continuance. The motion shall state good cause.

(E) Order of Proof. Regardless of which party has the burden of proof petitioner shall present evidence first unless the presiding officer orders otherwise.

(F) Default. If a party fails to appear at hearing, the party shall be in default.

1. If petitioner defaults, and petitioner has the burden of proof, the commission may dismiss the case for failure to prosecute.

2. If any party defaults, any other party may present evidence, and the defaulting party shall have waived any objection to such evidence. Such evidence shall constitute the sole evidentiary basis for disposition of the case, unless the commission orders otherwise.

(20) Transcripts.

(A) The court reporter shall file a transcript of all hearings with the commission. Any person may purchase a copy of the transcript through the court reporter.

(B) Any party may move to correct the transcript no more than ninety days after the court reporter files the transcript. The commission on its own motion may order the hearing reporter to correct the transcript any time before the commission finally disposes of the case.

(21) Fees and Expenses. A party may apply for litigation fees and expenses as authorized by law. Such application shall be an initial pleading in a separate case. The case for fees and expenses shall be governed by this rule.

AUTHORITY: section 643.050, RSMo 2000. Original rule filed May 12, 2005.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing on this proposed rule will begin at 9:00 a.m., July 21, 2005. The public hearing will be held at the Holiday Inn, Salon D, 2781 North Westwood Boulevard, Poplar Bluff, Missouri. Opportunity to be heard at the hearing shall be afforded any interested person. Written request to be heard should be submitted at least seven (7) days prior to the hearing to Director, Missouri Department of Natural Resources' Air Pollution Control Program, 205 Jefferson Street, PO Box 176, Jefferson City, MO 65102-0176, (573) 751-4817. Interested persons, whether or not heard, may submit a written statement of their views until 5:00 p.m., July 28, 2005. Written comments shall be sent to Chief, Operations Section, Missouri Department of Natural Resources' Air Pollution Control Program, 205 Jefferson Street, PO Box 176, Jefferson City, MO 65102-0176.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 6—Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

PROPOSED AMENDMENT

10 CSR 10-6.110 Submission of Emission Data, Emission Fees and Process Information. The commission proposes to amend subsection (3)(D). If the commission adopts this rule action, it will be submitted to the U.S. Environmental Protection Agency to replace the current rule in the Missouri State Implementation Plan. The evidence supporting the need for this proposed rulemaking is available for viewing at the Missouri Department of Natural Resources' Air Pollution Control Program at the address and phone number listed in the Notice of Public Hearing at the end of this rule. More information concerning this rulemaking can be found at the Missouri Department of Natural Resources' Environmental Regulatory Agenda website, www.dnr.mo.gov/regs/regagenda.htm.

PURPOSE: This rule provides procedures for collecting, recording, and submitting emission data and process information so that the state can calculate emissions for the purpose of state air resource planning. This amendment will establish emission fees for Missouri facilities as required annually and split the fee payment schedule to better align the collection of fee revenue with the state fiscal year it is to cover. The evidence supporting the need for this proposed rulemaking, per section 536.016, RSMo, is section 643.079 of the Missouri state statutes and a December 10, 2004 E-mail Re: Proposed 2005 Changes for 10 CSR 10-6.110.

(3) General Provisions.

(D) Emission Fees.

1. Any air contaminant source required to obtain a permit under sections 643.010–643.190, RSMo, except sources that produce charcoal from wood, shall pay an annual emission fee, regardless of their EIQ reporting frequency, of *[thirty-three dollars and no cents ($33.00)]* **thirty-five dollars and fifty cents ($35.50)** per ton of regulated air pollutant emitted starting with calendar year *[2004]* **2005** in accordance with the conditions specified in paragraph (3)(D)2. of this rule. Sources which are required to file reports once every five (5) years may use the information in their most recent EIQ to determine their annual emission fee.

2. General requirements.

A. The fee shall apply to the first four thousand (4,000) tons of each regulated air pollutant emitted. However, no air contaminant source shall be required to pay fees on total emissions of regulated air pollutants in excess of twelve thousand (12,000) tons in any calendar year. A permitted air contaminant source which emitted less than one (1) ton of all regulated pollutants shall pay a fee equal to the amount of one (1) ton.

B. The fee shall be based on the information provided in the facility's EIQ.

C. An air contaminant source which pays emissions fees to a holder of a certificate of authority issued pursuant to section 643.140, RSMo, may deduct those fees from the emission fee due under this section.

D. The fee imposed under paragraph (3)(D)1. of this rule shall not apply to carbon oxide emissions.

E. The fees **for emissions produced during the previous calendar year** shall be due April 1 each year *[for emissions produced during the previous calendar year]* **for all United States Department of Labor Standard Industrial Classifications except for Standard Industrial Classification 4911 Electric Services which shall be due June 1 each year. The fees shall be payable to the Department of Natural Resources.**

F. *[The fees shall be payable to the Department of Natural Resources and shall be accompanied by the]* **All** Emissions Inventory Questionnaire forms or equivalent approved by the director **shall be due April 1 each year for all United States Department of Labor Standard Industrial Classifications except for Standard Industrial Classification 4911 Electric Services which shall be due June 1 each year**.

G. For the purpose of determining the amount of air contaminant emissions on which the fees are assessed, a facility shall be considered one (1) source under the definition of section 643.078.2, RSMo, except that a facility with multiple operating permits shall pay emission fees separately for air contaminants emitted under each individual permit.

3. Fee collection. The annual changes to this rule to establish emission fees for a specific year do not relieve any source from the payment of emission fees for any previous year.

AUTHORITY: section 643.050, RSMo 2000. Original rule filed June 13, 1984, effective Nov. 12, 1984. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed May 16, 2005.*

PUBLIC COST: This proposed amendment will result in an annualized aggregate gain in revenue of two hundred thirty-eight thousand five hundred forty-seven dollars ($238,547) for the Department of Natural Resources. This gain in revenue takes into account an annualized aggregate cost of two hundred thirty-five thousand nine hundred eighty-eight dollars ($235,988) for other public entities. Note attached fiscal note for assumptions that apply.

PRIVATE COST: This proposed amendment will result in an annualized aggregate cost of two hundred thirty-eight thousand five hundred forty-seven dollars ($238,547) for private entities. Note attached fiscal note for assumptions that apply.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing on this proposed amendment will begin at 9:00 a.m., July 21, 2005. The public hearing will be held at the Holiday Inn, 2781 North Westwood Boulevard, Poplar Bluff, Missouri 63901. Opportunity to be heard at the hearing shall be afforded any interested person. Written request to be heard should be submitted at least seven (7) days prior to the hearing to Director, Missouri Department of Natural Resources' Air Pollution Control Program, 205 Jefferson Street, PO Box 176, Jefferson City, MO 65102-0176, (573) 751-4817. Interested persons, whether or not heard, may submit a written statement of their views until 5:00 p.m., July 28, 2005. Written comments shall be sent to Chief, Operations Section, Missouri Department of Natural Resources' Air Pollution Control Program, 205 Jefferson Street, PO Box 176, Jefferson City, MO 65102-0176.

FISCAL NOTE
PUBLIC ENTITY COST

I. RULE NUMBER

Title: 10 - Department of Natural Resources
Division: 10 - Air Conservation Commission

Chapter: 6 - Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

Type of Rulemaking: Proposed Amendment

Rule Number and Name: 10 CSR 10 - 6.110 Submission of Emission Data, Emission Fees and Process Information

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Misc. Public Entities (listed below)	$ 235,988 Cost For This Amendment
Missouri Department of Natural Resources	$ 238,547 Increase in Revenue

Cost estimates are reported as annualized aggregates.

III. WORKSHEET

	EIQ Fee Costs		
	FY2006	FY2007**	Annualized Aggregate
EIQ Fees ($35.50 Fee)	$1,520,658	$1,509,754	$1,472,517

	EIQ Fee Costs		
	FY2006	FY2007**	Annualized Aggregate
EIQ Fees ($33.00 Fee)	$1,181,900	$1,193,719	$1,236,529

Aggregate EIQ Fee Cost For This Amendment***	$235,988
Increase In Public Entity Fee Revenue For This Amendment***	$474,535
Resulting Gain In Public Entity Fee Revenue For This Amendment***	$238,547

*See Assumption 3.
**The first full fiscal year for this rulemaking is FY2007.
***Difference in annualized aggregate costs when raising $33.00 fee to $35.50 .

List of Affected Entities:

Source Description	Number of Facilities
Gas & Electric	47
Sanitary Services	32
Hospitals	21
Rehabilitation Centers	2
Schools	9
Correctional Facility	8
National Security	6
Post Office	2
Transportation	3
Other	14
Totals	144

IV. ASSUMPTIONS

1. For the convenience of calculating this fiscal note over a reasonable time frame, the life of the rule is assumed to be ten (10) years although the duration of the rule is indefinite. If the life of the rule extends beyond ten years, the annual costs for additional years will be consistent with the assumptions used to calculate annual costs as identified in this fiscal note.

2. The public entity costs are fee collection estimates. The costs are based on the most recent data available to the department and are expected to be more accurate than previous fiscal notes for the same fiscal years.

3. The fees for emissions produced during the previous calendar year shall be due April 1 each year for all United States Department of Labor Standard Industrial Classifications except for Standard Industrial Classification 4911 Electric Services which shall be due June 1 each year. For example, costs for all calendar year 2005 emission fees are received by the Missouri Department of Natural Resources between January 1, 2006 and June 30, 2006.

4. Cost and affected entity estimates are based on data presently entered in the tracking systems of the Missouri Department of Natural Resources' Air Pollution Control Program. This data is subject to change as additional information is reviewed, updated, and entered.

5. Fees for public entities are based on $35.50 per ton of regulated air pollutant for calendar 2005. This fee represents an $2.50 dollar increase from the emissions fee of $33.00 per ton of regulated air pollutant for calendar year 2004.

6. The emission fees paid by public entities may vary depending on their current information and their chargeable emissions with fees remaining relatively constant. However, new controls decrease the amount of their emission fees.

7. The percent difference between the two most recent years of actual facility emissions is used to project future year facility emissions.

8. Compliance and EIQ preparation costs reported on EIQs are not included in this fiscal note because these costs are not a result of this rulemaking. Compliance and preparation costs have been included in fiscal notes for the rulemakings that implemented these requirements.

9. The aggregate gain in public entity fee revenue for the Missouri Department of Natural Resources' Air Pollution Control Program is directly related to the difference in emission fees. The net gain in revenue is equivalent to the amount of gain realized by both public and private entities paying emission fees.

FISCAL NOTE
PRIVATE ENTITY COST

I. RULE NUMBER

Title: 10 - Department of Natural Resources

Division: 10 - Air Conservation Commission

Chapter: Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

Type of Rulemaking: Proposed Amendment

Rule Number and Name: 10 CSR 10 - 6.110 Submission of Emission Data, Emission Fees and Process Information

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
2,340 Facilities (listed below)	Listed below	$ 238,547 Cost For This Amendment

Cost estimates are reported as annualized aggregates.

III. WORKSHEET

	EIQ Fee Costs		
	FY2006	FY2007**	Annualized Aggregate
EIQ Fees ($35.50 Fee)	$8,153,373	$8,094,908	$7,895,249

	EIQ Fee Costs		
	FY2006	FY2007**	Annualized Aggregate
EIQ Fees ($33.00 Fee)	$7,318,435	$7,391,619	$7,656,702

Total Aggregate Cost For This Amendment***	$238,547

*See Assumption 3.
**The first full fiscal year for this rulemaking is FY2007.
***Difference in annualized aggregate costs when raising $33.00 fee to $35.50 .

List of Affected Entities:

SIC Code	SIC Description	Number of Facilities
01	AGRICULTURAL PRODUCTION-CROPS	0
02	AGRICULTURAL PRODUCTION-LIVESTOCK AND ANIMAL SPECIALTIES	1
07	AGRICULTURAL SERVICES	50

SIC Code	SIC Description	Number of Facilities
08	FORESTRY	0
09	FISHING, HUNTING AND TRAPPING	0
10	METAL MINING	6
12	COAL MINING	4
13	OIL AND GAS EXTRACTION	0
14	MINING AND QUARRYING OF NONMETALLIC MINERALS, EXCEPT FUELS	303
15	BUILDING CONSTRUCTION-GENERAL CONTRACTORS AND OPERATIVE	1
16	HEAVY CONSTRUCTION OTHER THAN BUILDING CONSTRUCTION	0
17	CONSTRUCTION-SPECIAL TRADE CONTRACTORS	2
20	FOOD AND KINDRED PRODUCTS	114
21	TOBACCO PRODUCTS	0
22	TEXTILE MILL PRODUCTS	1
23	APPAREL AND OTHER FINISHED PRODUCTS MADE FROM FABRICS	0
24	LUMBER AND WOOD PRODUCTS, EXCEPT FURNITURE	59
25	FURNITURE AND FIXTURES	23
26	PAPER AND ALLIED PRODUCTS	22
27	PRINTING, PUBLISHING, AND ALLIED INDUSTRIES	61
28	CHEMICALS AND ALLIED PRODUCTS	129
29	PETROLEUM REFINING AND RELATED INDUSTRIES	120
30	RUBBER AND MISCELLANEOUS PLASTICS PRODUCTS	62
31	LEATHER AND LEATHER PRODUCTS	6
32	STONE, CLAY, GLASS, AND CONCRETE PRODUCTS	343
33	PRIMARY METAL INDUSTRIES	46
34	FABRICATED METAL PRODUCTS, EXCEPT MACHINERY AND TRANSPORTATION	77

SIC Code	SIC Description	Number of Facilities
35	INDUSTRIAL AND COMMERCIAL MACHINERY AND COMPUTER EQUIPMENT	46
36	ELECTRONIC AND OTHER ELECTRICAL EQUIPMENT AND COMPONENTS	35
37	TRANSPORTATION EQUIPMENT	66
38	MEASURING, ANALYZING, AND CONTROLLING INSTRUMENTS	3
39	MISCELLANEOUS MANUFACTURING INDUSTRIES	17
40	RAILROAD TRANSPORTATION	0
41	LOCAL AND SUBURBAN TRANSIT AND INTERURBAN HIGHWAY PASSENGER	1
42	MOTOR FREIGHT TRANSPORTATION AND WAREHOUSING	11
43	UNITED STATES POSTAL SERVICE	0
44	WATER TRANSPORTATION	3
45	TRANSPORTATION BY AIR	2
46	PIPELINES, EXCEPT NATURAL GAS	24
47	TRANSPORTATION SERVICES	4
48	COMMUNICATIONS	5
49	ELECTRIC, GAS, SANITARY SERVICES, AND LANDFILLS	94
50	WHOLESALE TRADE-DURABLE GOODS	18
51	WHOLESALE TRADE-NON-DURABLE GOODS	144
52	BUILDING MATERIALS, HARDWARE, GARDEN	0
53	GENERAL MERCHANDISE STORES	0
54	FOOD STORES	0
55	AUTOMOTIVE DEALERS AND GASOLINE SERVICE STATIONS	1
56	APPAREL AND ACCESSORY STORES	0
57	HOME FURNITURE, FURNISHINGS, AND EQUIPMENT STORES	0
58	EATING AND DRINKING PLACES	0
59	MISCELLANEOUS RETAIL	1
60	DEPOSITORY INSTITUTIONS	0

SIC Code	SIC Description	Number of Facilities
61	NONDEPOSITORY CREDIT INSTITUTIONS	0
62	SECURITY & COMMODITY BROKERS, DEALERS	0
63	INSURANCE CARRIERS	0
64	INSURANCE AGENTS, BROKERS AND SERVICES	0
65	REAL ESTATE	2
67	HOLDING AND OTHER INVESTMENT OFFICES	1
70	HOTELS, ROOMING HOUSES, CAMPS, AND OTHER LODGING PLACES	1
72	PERSONAL SERVICES AND DRY CLEANERS	331
73	BUSINESS SERVICES	4
75	AUTOMOTIVE REPAIR, SERVICES, AND PARKING	6
76	MISCELLANEOUS REPAIR SERVICES	1
78	MOTION PICTURES	0
79	AMUSEMENT AND RECREATION SERVICES	1
80	HEALTH SERVICES	36
81	LEGAL SERVICES	0
82	EDUCATIONAL SERVICES	6
83	SOCIAL SERVICES	1
84	MUSEUMS, ART GALLERIES, AND BOTANICAL AND ZOOLOGICAL GARDENS	0
86	MEMBERSHIP ORGANIZATIONS	0
87	ENGINEERING, ACCOUNTING, RESEARCH, MANAGEMENT, AND RELATED	4
88	PRIVATE HOUSEHOLDS	0
89	SERVICES NOT ELSEWHERE CLASSIFIED	0
91	EXECUTIVE, LEGISLATIVE, AND GENERAL GOVERNMENT, EXCEPT FINANCE	0
92	JUSTICE, PUBLIC ORDER AND SAFETY	3
93	PUBLIC FINANCE, TAXATION & MONETARY	0
94	ADMINISTRATION OF HUMAN RESOURCE PERSONNEL	0
95	ADMINISTRATION OF ENVIRONMENTAL QUALITY AND HOUSING PROGRAMS	0

SIC Code	SIC Description	Number of Facilities
96	ADMINISTRATION OF ECONOMIC PROGRAMS	1
97	NATIONAL SECURITY AND INTERNATIONAL AFFAIRS	1
99	UNKNOWN	36
	Total Facilities	2,340

IV. ASSUMPTIONS

1. For the convenience of calculating this fiscal note over a reasonable time frame, the life of the rule is assumed to be ten (10) years although the duration of the rule is indefinite. If the life of the rule extends beyond ten years, the annual costs for additional years will be consistent with the assumptions used to calculate annual costs as identified in this fiscal note.

2. The private entity costs are fee collection estimates. The costs are based on the most recent data available to the department and are expected to be more accurate than previous fiscal notes for the same fiscal years.

3. The fees for emissions produced during the previous calendar year shall be due April 1 each year for all United States Department of Labor Standard Industrial Classifications except for Standard Industrial Classification 4911 Electric Services which shall be due June 1 each year. For example, costs for all calendar year 2005 emission fees are received by the Missouri Department of Natural Resources between January 1, 2006 and June 30, 2006.

4. Cost and affected entity estimates are based on data presently entered in the tracking systems of the Missouri Department of Natural Resources' Air Pollution Control Program. This data is subject to change as additional information is reviewed, updated, and entered.

5. Fees for private entities are based on $35.50 per ton of regulated air pollutant for calendar 2005. This fee represents an $2.50 dollar increase from the emissions fee of $33.00 per ton of regulated air pollutant for calendar year 2004.

6. The emission fees paid by private entities may vary depending on their current information and their chargeable emissions with fees remaining relatively constant. However, new controls decrease the amount of their emission fees.

7. The percent difference between the two most recent years of actual facility emissions is used to project future year facility emissions.

8. Compliance and EIQ preparation costs reported on EIQs are not included in this fiscal note because these costs are not a result of this rulemaking. Compliance and preparation costs have been included in fiscal notes for the rulemakings that implemented these requirements.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 107—Sales/Use Tax—Exemption Certificates

PROPOSED AMENDMENT

12 CSR 10-107.100 Use of and Reliance on Exemption Certificates. The director proposes to delete section (5).

*PURPOSE: This amendment is necessary to have the annotations removed from the body of the rule. The annotations will be placed in the **Code of State Regulations** following the rule.*

[(5) Annotations.

(A) All Star Amusement, Inc. v. Director of Revenue, 873 S.W.2d 843 (Mo. banc 1994). A seller that accepts an exemption certificate in good faith is not required to collect and remit tax on the sale. There is no requirement that a seller accept an exemption certificate contemporaneously with the sale or that the certificate be dated to fulfill the good faith requirement. However, the fact that an exemption certificate is received after the sale or is not dated may influence a factual finding on the issue of the seller's good faith.

(B) Conagra Poultry Co. v. Director of Revenue, 862 S.W.2d 915 (Mo. banc 1993). In order to accept an exemption certificate in good faith, a seller must act with honesty of intention and freedom from knowledge that ought to put the seller on notice. When seller prepared the exemption certificates two (2) years after the transaction and obtained the buyer's signatures, the seller did not act in good faith.

(C) Director of Revenue v. Armco, Inc., 787 S.W.2d 722 (Mo. banc 1993). Failure by seller to provide exemption certificates at time of department audit forfeited the right to claim the sales were exempt.

(D) Cadwell Supermarket, Inc. v. Director of Revenue (AHC 1997). When seller's employees personally knew the buyers were purchasing for exempt purposes, failure to obtain exemption certificates did not defeat the exemption claim.]

AUTHORITY: section 144.270, RSMo 2000. Original rule filed Oct. 25, 2004, effective May 30, 2005. Amended: Filed May 10, 2005.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Revenue, Office of Legislation and Regulations, PO Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 3—Conditions of Provider Participation, Reimbursement and Procedure of General Applicability

PROPOSED AMENDMENT

13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services. The division is adding a new section (1), amending and renumbering old sections (1) and (2) and renumbering the remaining sections.

PURPOSE: This amendment clarifies what documentation a provider of a Medicaid service must keep in order to avoid violating this section and therefore receiving a sanction.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Administration. The Missouri Medicaid program shall be administered by the Department of Social Services, Division of Medical Services. The services covered and not covered, the limitations under which services are covered, and the maximum allowable fees for all covered services shall be determined by the division and shall be included in the Medicaid provider manuals, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65102, at its website www.dss.mo.gov/dms, June 15, 2005. This rule does not incorporate any subsequent amendments or additions. The division reserves the right to affect changes in services, limitations, and fees with notification to providers.

[(1)] **(2)** The following definitions will be used in administering this rule:

(A) Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty. Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnosis, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation must be made available at the same site at which the service was rendered. **An adequate and complete patient record is a record which is legible, which is made contemporaneously with the delivery of the service, which addresses the patient/client specifics, which include, at a minimum, individualized statements that support the assessment or treatment encounter, and shall include documentation of the following information:**

1. First name, and last name, and either middle initial or date of birth of the Medicaid recipient;

2. An accurate, complete, and legible description of each service(s) provided;

3. Name, title, and signature of the Missouri Medicaid enrolled provider delivering the service. Inpatient hospital services must have signed and dated physician or psychologist orders within the patient's medical record for the admission and for services billed to Missouri Medicaid. For patients registered on hospital records as outpatient, the patient's medical record must contain signed and dated physician orders for services billed to Missouri Medicaid. Services provided by an individual under the direction or supervision are not reimbursed by Missouri Medicaid. Services provided by a person not enrolled with Missouri Medicaid are not reimbursed by Missouri Medicaid;

4. The name of the referring entity, when applicable;

5. The date of service (month/day/year);

6. For those Medicaid programs and services that are reimbursed according to the amount of time spent in delivering or rendering a service(s) (except for services as specified under 13

CSR 70-91.010 Personal Care Program (4)(A)) the actual begin and end time taken to deliver the service (for example, 4:00–4:30 p.m.) must be documented;

7. The setting in which the service was rendered;

8. The plan of treatment, evaluation(s), test(s), findings, results, and prescription(s) as necessary. Where a hospital acts as an independent laboratory or independent radiology service for persons considered by the hospital as "nonhospital" patients, the hospital must have a written request or requisition slip ordering the tests or procedures;

9. The need for the service(s) in relationship to the Medicaid recipient's treatment plan;

10. The Medicaid recipient's progress toward the goals stated in the treatment plan (progress notes); and

11. For applicable programs it is necessary to have adequate invoices, trip tickets/reports, activity log sheets, employee records (excluding health records), and training records of staff;

(B) Affiliates means persons having an overt, covert or conspiratorial relationship so that any one (1) of them directly or indirectly controls or has the power to control another;

(C) Closed-end provider agreement means an agreement that is for a specified period of time, not to exceed twelve (12) months, and that must be renewed in order for the provider to continue to participate in the Medicaid program;

(D) Contemporaneous means at the time the service was performed or within seventy-two (72) hours of the time the service was provided;

(E) Federal health care program means a program as defined in section 1128B(f) of the Social Security Act;

*[(D)]***(F)** Fiscal agent means an organization under contract to the state Medicaid agency for providing any services in the administration of the Medicaid program;

*[(E)]***(G)** Medicaid agency or the agency means the single state agency administering or supervising the administration of a state Medicaid plan;

*[(F)]***(H)** Open-end provider agreement means an agreement that has no specific termination date and continues in force as long as it is agreeable to both parties;

*[(G)]***(I)** Participation means the ability and authority to provide services or merchandise to eligible Medicaid recipients and to receive payment from the Medicaid program or those services or merchandise;

*[(H)]***(J)** Person means any natural person, company, firm, partnership, unincorporated association, corporation or other legal entity;

*[(I)]***(K)** Provider means an individual, firm, corporation, pharmacy, hospital, long-term care facility, association or institution which has a provider agreement to provide services to a recipient pursuant to Chapter 208, RSMo;

*[(J)]***(L)** Record*[s]* means any books, papers, journals, charts, treatment histories, medical histories, tests and laboratory results, photographs, X rays and any other recordings of data or information made by or caused to be made by a provider relating in any way to services provided to Medicaid recipients and payments charged or received. Medicaid claim for payment information**,** appointment books, financial ledgers, financial journals or any other kind of patient charge without corresponding adequate medical records do not constitute adequate documentation;

*[(K)]***(M)** Supervision means *[the service was performed while the provider was physically present during the service or the provider was on the premises and readily available to give direction to the person actually performing the service]* **to direct an employee of the provider in the performance of a covered and allowable service such as under the Missouri Medicaid dental and nurse midwife programs or a covered and allowable nonpsychiatric service under the Missouri Medicaid physician program. In order to direct the performance of such service, the provider must be in the office where the service is being provided and must be immediately available to give directions in person to the employee actually rendering the service and the adequately documented service must be cosigned by the enrolled billing provider**;

*[(L)]***(N)** Suspension from participation means an exclusion from participation for a specified period of time;

*[(M)]***(O)** Suspension of payments means placement of payments due a provider in an escrow account;

*[(N)]***(P)** Termination from participation means the ending of participation in the Medicaid program; and

*[(O)]***(Q)** Withholding of payments means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to the providers.

[(2)] **(3)** Program Violations.

(A) Sanctions may be imposed by the Medicaid agency against a provider for any one (1) or more of the following reasons:

1. Presenting, or causing to be presented, for payment any false or fraudulent claim for services or merchandise in the course of business related to Medicaid;

2. Submitting, or causing to be submitted, false information for the purpose of obtaining greater compensation than that to which the provider is entitled under applicable Medicaid program policies or rules, including, but not limited to, the billing or coding of services which results in payments in excess of the fee schedule for the service actually provided or billing or coding of services which results in payments in excess of the provider's charges to the general public for the same services **or billing for higher level of service or increased number of units from those actually ordered or performed or both**, or altering or falsifying medical records to obtain or verify a greater payment than authorized by a fee schedule or reimbursement plan;

3. Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization requirements or for the purpose of obtaining payments in order to avoid the effect of those changes;

4. *[Making]* **Failing to make** available, and disclosing to the Medicaid agency or its authorized agents, all records relating to services provided to Medicaid recipients *[and]* **or records relating to** Medicaid payments, whether or not the records are commingled with non-Title XIX **(Medicaid)** records *[is mandatory for all providers]*. **All records must be kept a minimum of five (5) years from the date of service unless a more specific provider regulation applies. The minimum five (5)-year retention of records requirement continues to apply in the event of a change of ownership or discontinuing enrollment in Medicaid. Services billed to the Medicaid agency that are not adequately documented in the patient's medical records or for which there is no record that services were performed shall be considered a violation of this section.** Copies of records must be provided upon request of the Medicaid agency or its authorized agents**, regardless of the media in which they are kept**. Failure to make these records available on a timely basis at the same site at which the services were rendered **or at the provider's address of record with the Medicaid agency**, or failure to provide copies as requested, or failure to keep and make available adequate records which adequately document the services and payments shall constitute a violation of this section and shall be a reason for sanction**. Failure to send records, which have been requested via mail, within the specified time frame shall constitute a violation of this section and shall be a reason for sanction**;

5. Failing to provide and maintain quality, necessary and appropriate services, including adequate staffing for long-term care facility Medicaid recipients, within accepted medical community standards as adjudged by a body of peers, as set forth in both federal and state statutes or regulations. Failure shall be documented by repeat discrepancies. The discrepancies may be determined by a peer review committee, medical review teams, independent professional review

teams, utilization review committees or by Professional Standards Review Organizations (PSRO). The medical review may be conducted by qualified peers employed by the single state agency;

6. Engaging in conduct or performing an act deemed improper or abusive of the Medicaid program or continuing the conduct following notification that the conduct should cease. This will include inappropriate or improper actions relating to the management of recipients' personal funds or other funds;

7. Breaching of the terms of the Medicaid provider agreement of any current written and published policies and procedures of the Medicaid program (such as are contained in provider manuals or bulletins **which are incorporated by reference and made a part of this rule as published by the Department of Social Services, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65102, at its website www.dss.mo.gov/dms, June 15, 2005. This rule does not incorporate any subsequent amendments or additions. The division reserves the right to affect changes in services, limitations, and fees with notification to providers.)** or failing to comply with the terms of the provider certification on the Medicaid claim form;

8. Utilizing or abusing the Medicaid program as evidenced by a documented pattern of inducing, furnishing or otherwise causing a recipient to receive services or merchandise not otherwise required or requested by the recipient, attending physician or appropriate utilization review team; a documented pattern of performing and billing tests, examinations, patient visits, surgeries, drugs or merchandise that exceed limits or frequencies determined by the department for like practitioners for which there is no demonstrable need, or for which the provider has created the need through ineffective services or merchandise previously rendered;

9. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral; or collecting a portion of the service fee from the recipient, except this shall not apply to Title XIX services for which recipients are responsible for payment of a copayment or coinsurance in accordance with 13 CSR 70-4.051 and 13 CSR 70-55.010;

10. Violating any provision of the State Medical Assistance Act or any corresponding rule;

11. Submitting a false or fraudulent application for provider status which misrepresents material facts. This shall include concealment or misrepresentation of material facts required on any provider agreements or questionnaires submitted by affiliates when the provider knew or should have known the contents of the submitted documents;

12. Violating any laws, regulations or code of ethics governing the conduct of occupations or professions or regulated industries. In addition to all other laws which would commonly be understood to govern or regulate the conduct of occupations, professions or regulated industries, this provision shall include any violations of the civil or criminal laws of the United States, of Missouri or any other state or territory, where the violation is reasonably related to the provider's qualifications, functions or duties in any licensed or regulated profession or where an element of the violation is fraud, dishonesty, moral turpitude or an act of violence;

13. Failing to meet standards required by state or federal law for participation (for example licensure);

14. *[Excluding]* **Exclusion** from *[Medicare for any reason arising out of improper conduct related to]* the Medicare program **or any other federal health care program**;

15. Failing to accept Medicaid payment as payment in full for covered services or collecting additional payment from a recipient or responsible person, except this shall not apply to Title XIX services for which recipients are responsible for payment of a copayment or coinsurance in accordance with 13 CSR 70-4.051 and 13 CSR 70-55.010;

16. Refusing to execute a new provider agreement when requested to do so by the single state agency in order to preserve the single state agency's compliance with federal and state requirements; or failure to execute an agreement within twenty (20) days for compliance purposes;

17. Failing to correct deficiencies in provider operations within ten (10) days **or date specified** after receiving written notice *[established by a signed receipt of delivery]* of these deficiencies from the single state agency or within the time frame provided from any other agency having licensing or certification authority;

18. Being formally reprimanded or censured by a board of licensure or an association of the provider's peers for unethical, unlawful or unprofessional conduct; any termination, removal, suspension, revocation, denial, probation, consented surrender or other disqualification of all or part of any license, permit, certificate or registration related to the provider's business or profession in Missouri or any other state or territory of the United States;

19. Being suspended or terminated from participation in another governmental medical program such as Workers' Compensation, Crippled Children's Services, Rehabilitation Services**,** *[and]* **Title XX Social Service Block Grant or** Medicare;

20. Using fraudulent billing practices arising from billings to third parties for costs of services or merchandise or for negligent practice resulting in death or injury or substandard care to persons including, but not limited to, the provider's patients;

21. Failing to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments prior to the allowed forty-five (45) days which the provider has to refund the requested amount;

22. Billing the Medicaid program *[twice]* **more than once** for the same service when the billings were not caused by the single state agency or its agents;

23. Billing the state Medicaid program for services not provided prior to the date of billing (prebilling), except in the case of prepaid health plans or pharmacy claims submitted by point-of-service technology; whether or not the prebilling causes loss or harm to the Medicaid program;

24. Failing to reverse **or credit back to the medical assistance program (Medicaid) within thirty (30) days** any pharmacy claims submitted *[by point-to-service technology while representing]* **to the agency that represent products or** services not received by the recipient*[, by the time established by pharmacy manual on the Friday evening following the date the claim was submitted by point-of-service technology.]***; for example, prescriptions that were returned to stock because they were not picked up;**

25. Conducting any action resulting in a reduction or depletion of a long-term care facility Medicaid recipient's personal funds or reserve account, unless specifically authorized in writing by the recipient, relative or responsible person;

26. *[Providing services by a nonenrolled person without the direct supervision of a provider and billed by the provider as having performed those services, or services billed by a provider but performed by a similarly licensed practitioner, nonenrolled due to Medicaid sanction, whether or not the performing practitioner was under supervision of the billing provider]* **Submitting claims for services not personally rendered by the individually enrolled provider, except for the provisions specified in the Missouri Medicaid dental, physician, or nurse midwife programs where such claims may be submitted only if the individually enrolled provider directly supervised the person who actually performed the service and the person was employed by the enrolled provider at the time the service was rendered. All claims for psychiatric, psychological counseling, speech therapy, physical therapy, and occupational therapy services may only be billed by the individually enrolled provider who actually performs the service, as supervision is noncovered for these services. Services performed by a nonenrolled person due to Medicaid sanction, whether or not the person was under supervision of the enrolled provider, is a noncovered service**;

27. Making any payment to any person in return for referring an individual to the provider for the delivery of any goods or services for which payment may be made in whole or in part under Medicaid. Soliciting or receiving any payment from any person in return for referring an individual to another supplier of goods or services regardless of whether the supplier is a Medicaid provider for the delivery of any goods or services for which payment may be made in whole or in part under Medicaid is also prohibited. Payment includes, without limitation, any kickback, bribe or rebate made, either directly or indirectly, in cash or in-kind;

28. *[Having]* **Billing for** services *[billed and rendered],* **through an agent,** which were upgraded from those actually ordered**, performed;** or billing or coding services**, either directly or through an agent,** in a manner that services are paid for as separate procedures when, in fact, the services were performed concurrently or sequentially and should have been billed or coded as integral components of a total service as prescribed in Medicaid policy for payment in a total payment less than the aggregate of the improperly separated services; **or billing a higher level of service than is documented in the patient/client record; or unbundling procedure codes;**

29. Conducting civil or criminal fraud against the Missouri Medicaid program or any other state Medicaid (medical assistance) program, or any criminal fraud related to the conduct of the provider's profession or business;

30. Having sanctions or any other adverse action invoked by another state Medicaid program;

31. Failing to take reasonable measures to review claims for payment for accuracy, duplication or other errors caused or committed by employees when the failure allows material errors in billing to occur. This includes failure to review remittance advice statements provided *[with the payment document]* which results in payments which do not correspond with the actual services rendered;

32. Submitting improper or false claims to the state or its fiscal agent by an agent or employee of the provider;

33. **For providers other than long-term care facilities,** *[F]***f**ailing to retain **in legible form for at least five (5) years from the date of service,** worksheets *[or]***, financial records, appointment books, appointment calendars (for those providers who schedule patient/client appointments), adequate documentation of the service, and** other documents and records verifying data transmitted to a billing intermediary, whether the intermediary is owned by the provider or not. *[The documentation must be retained for five (5) years. Long-term care providers are required to retain financial records for seven (7) years]* **For long-term care providers, failing to retain in legible form, for at least seven (7) years from the date of service, worksheets, financial records, adequate documentation for the service(s), and other documents and records verifying data transmitted to a billing intermediary, whether the intermediary is owned by the provider or not. The documentation must be maintained so as to protect it from damage or loss by fire, water, computer failure, theft, or any other cause**;

34. Removing or coercing from the possession or control of a recipient any item of durable medical equipment which has reached Medicaid-defined purchase price through Medicaid rental payments or otherwise become the property of the recipient without paying fair market value to the recipient;

35. Failing to timely submit civil rights compliance data or information or failure to timely take corrective action for civil rights compliance deficiencies within thirty (30) days after notification of these deficiencies or failure to cooperate or supply information required or requested by civil rights compliance officers of the single state agency; *[and]*

36. Billing the Medicaid program for services rendered to a recipient in a long-term care facility when the resident resided in a portion of the facility which was not Medicaid-certified or properly licensed or was placed in a nonlicensed or Medicaid-noncertified bed*[.]***;**

37. Failure to comply with the provisions of the state contract or agreement relating to health care services;

38. Failure to maintain documentation which is to be made contemporaneously to the date of service;

39. Failure to maintain records for services provided and all billing done under his/her provider number regardless to whom the reimbursement is paid and regardless of whom in his/her employ or service produced or submitted the Medicaid claim or both;

40. Failure to submit proper diagnosis codes, procedure codes, billing codes regardless to whom the reimbursement is paid and regardless of whom in his/her employ or service produced or submitted the Medicaid claim;

41. Failure to submit and document, as defined in subsection (2)(A) the length of time (begin and end clock time) actually spent providing a service, except for services as specified under 13 CSR 70-91.010(4)(A) Personal Care Program, regardless to whom the reimbursement is paid and regardless of whom in his/her employ or service produced or submitted the Medicaid claim or both; and

42. Billing for the same service as another provider when the service is performed or attended by more than one (1) enrolled provider. Missouri Medicaid will reimburse only one (1) provider for the exact same service.

*[(3)]***(4)** Any one (1) or more of the following sanctions may be invoked against providers for any one (1) or more of the program violations specified in section (2) of this rule:

(A) Failure to respond to notice of overpayments or notice of deficiencies in provider operations within the specified forty-five (45)-day time limit shall be considered cause to withhold future provider payments until the situation in question is resolved;

(B) Termination from participation in the Medicaid program for a period of not less than sixty (60) days nor more than ten (10) years;

(C) Suspension of participation in the Medicaid program for a specified period of time;

(D) Suspension or withholding of payments to a provider;

(E) Referral to peer review committees including PSROs or utilization review committees;

(F) Recoupment from future provider payments;

(G) Transfer to a closed-end provider agreement not to exceed twelve (12) months or the shortening of an already existing closed-end provider agreement;

(H) Attendance at provider education sessions;

(I) Prior authorization of services;

(J) One hundred percent (100%) review of the provider's claims prior to payment;

(K) Referral to the state licensing board for investigation;

(L) Referral to appropriate federal or state legal agency for investigation, prosecution, or both, under applicable federal and state laws;

(M) Retroactive denial of payments; and

(N) Denial of payment for any new admission to a skilled nursing facility (SNF), intermediate care facility (ICF) or ICF/mentally retarded (MR) that no longer meets the applicable conditions of participation (for SNFs) or standards (for ICFs and ICF/MRs) if the facility's deficiencies do not pose immediate jeopardy to patients' health and safety. Imposition of this sanction must be in accordance with all applicable federal statutes and regulations.

*[(4)]***(5)** Imposition of a Sanction.

(A) The decision as to the sanction to be imposed shall be at the discretion of the Medicaid agency. The following factors shall be considered in determining the sanction(s) to be imposed:

1. Seriousness of the offense(s)—The state agency shall consider the seriousness of the offense(s) including, but not limited to, whether or not an overpayment (that is, financial harm) occurred to the program, whether substandard services were rendered to Medicaid recipients, or circumstances were such that the provider's behavior could have caused or contributed to inadequate or dangerous medical care for any patient(s), or a combination of these. Violation of pharmacy laws or rules, practices potentially dangerous to patients and fraud are to be considered particularly serious;

2. Extent of violations—The state Medicaid agency shall consider the extent of the violations as measured by, but not limited to, the number of patients involved, the number of Medicaid claims involved, the number of dollars identified in any overpayment and the length of time over which the violations occurred. The Medicaid agency may calculate an overpayment or impose sanctions under this rule by reviewing records pertaining to all or part of a provider's Medicaid claims. When records are examined pertaining to part of a provider's Medicaid claims, no random selection process in choosing the claims for review as set forth in 13 CSR 70-3.130 need be utilized by the Medicaid agency. But, if the random selection process is not used, the Medicaid agency may not construe violations found in the partial review to be an indication that the extent of the violations in any unreviewed claims would exist to the same or greater extent;

3. History of prior violations—The state agency shall consider whether or not the provider has been given notice of prior violations of this rule or other program policies. If the provider has received notice and has failed to correct the deficiencies or has resumed the deficient performance, a history shall be given substantial weight supporting the agency's decision to invoke sanctions. If the history includes a prior imposition of sanction, the agency should not apply a lesser sanction in the second case, even if the subsequent violations are of a different nature;

4. Prior imposition of sanctions—The Medicaid agency shall consider more severe sanctions in cases where a provider has been subject to sanctions by the Missouri Medicaid program, any other governmental medical program, Medicare or exclusion by any private medical insurance carriers for misconduct in billing or professional practice. Restricted or limited participation in compromise after being notified or a more severe sanction should be considered as a prior imposition of a sanction for the purpose of this subsection;

5. Prior provision of provider education—In cases where sanctions are being considered for billing deficiencies only, the Medicaid agency may mitigate its sanction if it determines that prior provider education was not provided. In cases where sanctions are being considered for billing deficiencies only and prior provider education has been given, prior provider education followed by a repetition of the same billing deficiencies shall weigh heavily in support of the medical agency's decision to invoke severe sanctions; and

6. Actions taken or recommended by peer review groups, licensing boards or Professional Review Organizations (PRO) or utilization review committees—Actions or recommendations by a provider's peers shall be considered as serious if they involve a determination that the provider has kept or allowed to be kept, substandard medical records, negligently or carelessly performed treatment or services, or, in the case of licensing boards, placed the provider under restrictions or on probation.

(B) Where a provider has been convicted of defrauding any Medicaid program, has been previously sanctioned due to program abuse, has been terminated from the Medicare program, the Medicaid agency shall terminate the provider from participation in the Medicaid program.

(C) When a sanction involving the collection, recoupment or withholding of Medicaid payments from a provider is imposed on a provider, it shall become effective ten (10) days from the date the provider receives notice established by a signed receipt of delivery of the imposition of the sanction. When any other sanction is imposed on a provider it shall become effective thirty (30) days from the date the provider receives notice established by a signed receipt of delivery of the imposition of the sanction. If, in the judgment of the single state agency, the surrounding facts and circumstances clearly show that serious abuse or harm may result from delaying the imposition of a sanction, any sanction may be made effective immediately upon receipt of notice by the provider.

(D) A sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure or inadequacy of performance may be imputed to an affiliate when the affiliate knew or should have known of the provider's actions.

(E) Suspension or termination of any provider shall preclude the provider from participation in the Medicaid program, either personally or through claims submitted by any clinic, group, corporation or other association to the single state agency or its fiscal agents for any services or supplies provided under the Medicaid program except for those services or supplies provided prior to the suspension or termination.

(F) No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the single state agency or its fiscal agents for any services or supplies provided by, or under the supervision of, a person within the organization who has been suspended or terminated from participation in the Medicaid program except for those services or supplies provided prior to the suspension or termination.

(G) When the provisions of the previously mentioned are violated by a provider of services which is a clinic, group, corporation or other association, the single state agency may suspend or terminate the organization, the individual person, or both, within the organization who knew or should have known of the violation.

(H) When a provider has been sanctioned, the single state agency shall notify, as appropriate, the applicable professional society, board of registration or licensure, federal and state agencies of the finding made and the sanctions imposed.

(I) Where a provider's participation in the Medicaid program has been suspended or terminated, the single state agency shall notify the county offices of the suspensions or terminations.

(J) Except where termination has been imposed, a provider who has been sanctioned may be required to participate in a provider education program as a condition of continued participation. Provider education programs may include:

1. Telephone and written instructions;
2. Provider manuals and workshops;
3. Instruction in claim form completion;
4. Instruction on the use and format of provider manuals;
5. Instruction on the use of procedure codes;
6. Key provisions of the Medicaid program;
7. Instruction on reimbursement rates; and
8. Instruction on how to inquire about coding or billing problems.

(K) Providers that have been suspended from the Missouri Medicaid program under subsections *[(3)]***(4)**(B) and (C) may be reenrolled in the Medicaid program upon expiration of the period of suspension from the program after making satisfactory assurances of future compliance. Providers that have been terminated from the Missouri Medicaid program under subsection *[(3)]***(4)**(B) may be reenrolled in the program at the sole discretion of the single state agency and only after providing satisfactory evidence that the past cause for termination has ceased and that future participation is warranted.

*[(5)]***(6)** Amounts Due the Department of Social Services From a Provider.

(A) If there exists an amount due the Department of Social Services from a provider, the single state agency shall notify the provider or the provider's representative of the amount of the overpayment. If the amount due is not sooner paid to the Department of Social Services by or on behalf of the provider, the single state agency, forty-five (45) days from the date the provider receives the notice, established by a signed receipt of delivery, may take appropriate action to collect the overpayment. The single state agency may recover the overpayment by withholding from current Medicaid reimbursement. The withholding may be taken from one (1) or more payments until the funds withheld in the aggregate equal the amount due as stated in the notice.

(B) When a provider receives notice, established by a signed receipt of delivery, of an overpayment and the amount due is in excess of one thousand dollars ($1,000), the provider, within ten (10) days of the notice, may submit to the single state agency a plan for repayment of forty percent (40%) of the overpayment amount and request that the plan be adopted and adhered to by the single state agency in collecting the overpayment. No repayment plans will be considered for the first sixty percent (60%) of the overpayment amount. If this repayment plan is timely received from a provider, the single state agency shall consider the proposal, together with all the facts and circumstances of the case and reject, accept or offer to accept a modified version of the provider's plan for repayment. The single state agency shall notify the provider of its decision within ten (10) days after the proposal is received. If no plan for repayment is agreed upon within thirty (30) days after the provider receives notice of the overpayment, the Medicaid agency may take appropriate action to collect the balance of the amount due.

(C) If a plan agreed to and implemented under provisions of subsection *[(5)]***(6)**(B) for repayment of amounts due the Department of Social Services from a provider is breached, discontinued or otherwise violated by a provider, the single state agency, immediately upon the next payment to the provider, may begin to withhold payments or portions of payments until the entire amount due has been collected.

(D) Repayment or an agreement to repay amounts due the Department of Social Services by a provider shall not prevent the imposition of any sanction by the single state agency upon the provider.

*AUTHORITY: section 208.201, RSMo [Supp. 1987] **2000**. This rule was previously filed as 13 CSR 40-81.160. Original rule filed Sept. 22, 1979, effective Feb. 11, 1980. For intervening history, please consult the **Code of State Regulations**. Amended: Filed May 16, 2005.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of the Director, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication in the **Missouri Register**. If to be hand-delivered, comments must be brought to the Division of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 4—Conditions of Recipient Participation, Rights and Responsibilities

PROPOSED AMENDMENT

13 CSR 70-4.050 Copayment and Coinsurance for Certain Medicaid-Covered Services. The division is amending sections (1), (3), (6), (8), (9), (10), (11), (12) and deleting section (7) and adding four (4) new sections (13), (14), (15) and (16).

PURPOSE: This proposed amendment changes the copayment due from Medicaid recipients for physician-related services and hospital outpatient clinic or emergency room services.

(1) Recipients eligible to receive Missouri Medicaid services under certain program areas shall be required to pay a small portion of the costs of the services. The services to be affected by the copayment or coinsurance requirements are—

(F) **Hospital** *[O]***o**utpatient *[hospital]* clinic/emergency room services; and

(G) **All** *[P]***p**hysician**-related** services *[rendered in a hospital outpatient clinic or emergency room]*.

(3) Copayment charged shall be in accordance with 42 CFR 447.54 and, applicable to the services described in subsections (1)(A), (B) (excepting dentures), (C) *[and]***,** (D), **and (G),** based on the following schedule:

Medicaid Payment for Each Item of Service	**Recipient Copayment Amount**
$*[10.99]* **10** or less	$0.50
$*[11.00]* **10.01**–$25*[.99]*	$1.00
$*[26.00]* **25.01**–$50*[.99]*	$2.00
$*[51.00]* **50.01** or more	$3.00

(6) Copayment to be charged for hospital outpatient clinic or emergency room services shall be *[two dollars ($2)]* **three dollars ($3)** for each date of service on which the recipient receives, either one (1) or both, outpatient clinic or emergency room services.

[(7) Co-payment to be charged for physician services provided in a hospital outpatient clinic or emergency room shall be one dollar ($1) for each date of service on which the recipient receives these services.]

*[(8)]***(7)** *[With noted exceptions, t]***T**he following exemptions **apply** to the copayment requirement *[apply to the services]* **for services** described in subsections (1)(A)–(G):

(A) Services provided *[on or after December 1, 1984]* to recipients under *[eighteen (18)]* **nineteen (19)** years of age;

(B) Services to recipients residing within a skilled nursing home, an intermediate care nursing home, a residential care home, an adult boarding home or a psychiatric hospital;

(C) Services to recipients who have both Medicare and Medicaid entitlement if Medicare covers the service and provides payment for it;

(D) Emergency or transfer inpatient hospital admissions;

(E) Emergency services provided in an outpatient clinic or emergency room, *[such as—heart attack, hemorrhaging, poisoning, concussion, bone fractures or stroke]* **after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:**

1. Placing the patient's health in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part;

(F) Certain therapy services (physical therapy, chemotherapy, radiation therapy, psychotherapy and chronic renal dialysis) except when provided as an inpatient hospital service;

(G) Family planning services;

(H) Services provided to pregnant women *[which are directly related to the pregnancy or a complication of the pregnancy]*;

(I) Services provided to foster care recipients; *[and]*

(J) **Services identified as medically necessary through an** Early Periodic Screening, Diagnosis and Treatment **(EPSDT) screen** *[services.]***; and**

(K) Services provided through MC+ Managed Care Contracts.

[(9)] **(8) Providers are responsible for collecting the copayment or coinsurance amounts from individuals. The medical assistance program shall not increase its reimbursement to a provider to offset an uncollected copayment from a recipient. A provider shall collect a copayment from a recipient at the time each service is provided or at a later date.** Providers of services as described in this rule and as subject to a copayment or coinsurance requirement may not deny or reduce services otherwise eligible for Medicaid benefits on the basis of the recipient's inability to pay the due copayment or coinsurance amount when charged.

[(10)] **(9)** A recipient's inability to pay a required coinsurance or copayment amount, as due and charged when a service is delivered, in no way shall extinguish the recipient liability to pay the due amount **or prevent a provider from attempting to collect a copayment**.

[(11)] **(10)** Participation privileges in the Medicaid program shall be limited to providers who accept, as payment in full, the amounts paid by the state agency plus any coinsurance or copayment amount required of the recipient.

[(12)] **(11)** Providers of services in the program areas named must charge copayment or coinsurance as specified at the time the service is provided to retain their participation privileges in the Missouri Medicaid program.

[(13)] **(12)** Providers must maintain records of copayment or coinsurance amounts for five (5) years and must make those records available to the Department of Social Services upon request.

(13) If it is the routine business practice of a provider to discontinue future services to an individual with uncollected debt, the provider may include uncollected copayments under this practice.

(14) A provider shall give a Medicaid recipient a reasonable opportunity to pay an uncollected copayment.

(15) A provider shall give a Medicaid recipient with uncollected debt advanced notice and a reasonable opportunity to arrange care with a different provider before services can be discontinued.

(16) If a provider is not willing to provide services to a recipient with uncollected copayments and the requirements of this regulation have been met, the provider may discontinue future services to an individual with uncollected copayments. In accordance with 42 *Code of Federal Regulations* (CFR) 431.51, a recipient may obtain services from any qualified provider who is willing to provide services to that particular recipient and accept their ability/inability to pay the required copayments.

*AUTHORITY: sections [207.020] **208.152, RSMo Supp. 2004, 208.201**, RSMo [1986] **2000 and 208.215 as enacted by the 93rd General Assembly**. This rule was previously filed as 13 CSR 40-81.054. Emergency rule filed Oct. 21, 1981, effective Nov. 1, 1981, expired Feb. 10, 1982. Original rule filed Oct. 21, 1981, effective Feb. 11, 1982. Emergency amendment filed Jan. 21, 1983, effective Feb. 1, 1983, expired May 11, 1983. Amended: Filed Jan. 21, 1983, effective May 12, 1983. Amended: Filed Aug. 14, 1984, effective Nov. 11, 1984. Amended: Filed May 16, 2005.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities approximately twenty-three (23) million dollars based on state fiscal year 2004 utilization.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of the Director, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. If to be hand-delivered, comments must be brought to the Division of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

FISCAL NOTE

PRIVATE COST

I. RULE NUMBER

Rule Number and Name:	13 CSR 70-4.050 Copayment and Coinsurance for Certain Medicaid-Covered Services
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the count of compliance with the rule by the affected entities:
355,221	Medicaid recipients other than those noted exceptions listed in the assumptions	Unknown, no data is available on how many of the current Medicaid recipients required to pay co-payments actually pay
23,533	Medicaid enrolled hospitals and physician-related service providers	Providers will comply due to the systematic reduction of the co-payment from the provider's payment

III. WORKSHEET

The proposed amendment will provide for a standard, or fixed co-payment amount for any physician-related service and hospital outpatient clinic or emergency room service. This standard co-payment may be determined by applying the maximum co-payment amounts (specified below) to the agency's average or typical payment for that service. For example, if the agency's typical payment for a physician-related office visit is $20, the standard co-payment could be set at $1. The co-payments are charged on per encounter.

The co-payment to be charged for hospital outpatient clinic or emergency room services shall be $3 for each date of service on which the recipient receives, either one or both, outpatient clinic or emergency room services.

States Payment for the Service	Maximum Co-payment Chargeable to Recipient
$10 or less.....	$0.50
$10.01 to $25	$1.00
$25.01 to $50	$2.00
$50.01 or more	$3.00

The private cost of this proposed amendment is $23,000,000 based on the state fiscal year 2004 utilization of physician-related services and hospital outpatient clinic or emergency room services.

IV. ASSUMPTIONS

The proposed amendment changes the co-payment due from Medicaid recipients for physician-related services and hospital outpatient clinic or emergency room services pursuant to Senate Substitute for Senate Bill 539 enacted by the 93rd General Assembly, 2005.

Cost sharing may be either a deductible, or a coinsurance, or a co-payment, but not a combination of these on any single service. For any service, Medicaid programs may not impose more than one type of cost sharing.

The state will impose a nominal co-payment (as capped above) for any physician-related or hospital outpatient clinic or emergency room service and require certain recipients to share some of the costs of Medicaid.

The following recipients are excluded from co-payments:
- Children
- Pregnant women
- Institutionalized individuals (long-term care facility or other medical institution)
- Emergency services if the patient's health is in serious jeopardy, if there is serious impairment to bodily functions, or if there is serious dysfunctions of any bodily organ or part (Prudent Layperson)
- Family planning
- Hospice

The co-payment will be systematically deducted from the provider's Medicaid payment. No provider may deny services, to an individual who is eligible for the services, on account of the individual's inability to pay the cost sharing. The deduction of the co-payment, in many cases, would be a rate reduction for the provider and may cause access issues due to the potential for some providers to drop out of the Medicaid program or choose to not see some Medicaid clients.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 4—Conditions of Recipient Participation, Rights and Responsibilities

PROPOSED RULE

13 CSR 70-4.110 Placement of Liens on Property of Certain Institutionalized Medicaid Eligible Persons

PURPOSE: This rule implements the guidelines for placement of liens on the property of certain institutionalized Medicaid eligible persons, in accordance with the authority given to states in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), as amended.

(1) When an applicant for Medicaid or a Medicaid recipient is a patient, or will become a patient, in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, the Department of Social Services will determine if the placement of a lien against the property of the applicant or recipient is applicable. A lien is imposed on the property of an individual, in accordance with the authority given states in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), when:

(A) The Medicaid recipient is or has made application to become a patient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution, to spend for costs of medical care all but a minimal amount of his income required for personal needs;

(B) The institutionalized Medicaid recipient owns property. Property includes the homestead and all other real property in which the person has a sole legal interest or a legal interest based upon co-ownership of the property which is the result of a transfer of property for less than fair market value within thirty-six (36) months prior to the person entering the nursing facility;

(C) The department has determined after notice and opportunity for hearing that there is no reasonable expectation that the person can be discharged from the facility within one hundred twenty (120) days and return home. The hearing, if requested, will proceed under the provision of Chapter 536, RSMo, before a hearing officer designated by the director of the Department of Social Services. The fact that there is no reasonable expectation that the person can be discharged from the facility within one hundred twenty (120) days and return home may be substantiated by one (1) of the following:

1. Applicant/recipient states in writing that he/she does not intend to return home within one hundred twenty (120) days;

2. Applicant/recipient has been in the institution for longer than one hundred twenty (120) days; and

3. A physician states in writing that the applicant/recipient cannot be expected to be discharged within one hundred twenty (120) days of admission; and

(D) A lien is imposed on the property unless one (1) of the following persons lawfully resides in the property:

1. The institutionalized person's spouse;

2. The institutionalized person's child who is under twenty-one (21) years of age or is blind or permanently and totally disabled;

3. The institutionalized person's sibling who has an equity interest in the property and who was residing in such individual's home for a period of at least one (1) year immediately before the date of the individual's admission to the institution.

(2) After determining the applicability of the lien, the Medicaid recipient is given an Explanation of TEFRA Lien. A person who objects to the imposition of a lien is ineligible for medical assistance. Ineligibility is based on the person's objection without good cause to the imposition of the lien, which impedes the department's ability to implement its lien requirements.

(3) The director of the department or the director's designee will file for record, with the recorder of deeds of the county in which any real property is situated, a written Certificate of TEFRA Lien. The lien will contain the name of the Medicaid recipient and a description of the property. The recorder will note the time of receiving such notice and will record and index the certificate of lien in the same manner as deeds of real estate are required to be recorded and indexed. The county recorder shall be reimbursed by presenting a statement showing the number of certificates and releases filed each calendar quarter to the Department of Social Services.

(4) The TEFRA lien will be for the debt due the state for medical assistance paid or to be paid on behalf of the Medicaid recipient. The amount of the lien will be for the full amount due the state at the time the lien is enforced. Fees paid to county records of deeds for filing of the lien will be included in the amount of the lien.

(5) The TEFRA lien does not affect ownership interest in a property until it is sold, transferred, or leased, or upon the death of the individual, at which time the lien must be satisfied.

(6) The lien will be dissolved in the event the individual is discharged from the institution and returns home. A Notice of TEFRA Lien Release will be filed within thirty (30) days with the recorder of deeds of the county in which the original Certificate of TEFRA Lien was filed.

AUTHORITY: sections 208.201, RSMo 2000 and 208.215 as enacted by the 93rd General Assembly. Original rule filed May 16, 2005.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will cost private entities (medical assistance) less than one hundred thousand dollars ($100,000) in the aggregate over the first two (2) years of the life of the rule. In following years the medical assistance program will recover approximately one (1) million dollars a year from property with these liens.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Office of the Director, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. If to be hand-delivered, comments must be brought to the Division of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

FISCAL NOTE

PRIVATE COST

I. RULE NUMBER

Rule Number and Name:	13 CSR 70-4.110 Placement of Liens on Property of Certain Institutionalized Medicaid Eligible Persons
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the entities which would likely be affected:	Estimate in the aggregate as to the count affected by the rule:
	Individuals who are eligible for medical assistance who will stay in a nursing facility more than 120 days	90% will be impacted 10% will be exempted under the rule

III. WORKSHEET

Average Monthly NH Population	24,694
20% Property Owners	5,539
10% Exemption	4,985
3% Death Rate of NH Estate Cases	82
Property Value	$12,195
Annual Recovery Projection	$1,000,000

IV. ASSUMPTIONS

This proposed rule will cost private entities (medical assistance recipients) less than $100,000 in the aggregate over the first two years of the rule because liens will be filed but not collected until the death of the medical assistance recipient. The average length of stay in a nursing facility is three years. In following years the medical assistance program will recover approximately $1,000,000 a year from property with these liens.

Based on FY04 Table 5 statistical data, there are an average of 24,694 nursing facility residents per month. Assuming 20% of the residents own property, which is 5,539. Assuming 10% of the residents will be exempt as specified in the rule leaves 4,985 potential liens to be filed in the first

year. Since 3% of the Medicaid population are residents in nursing facilities, assume that 3% of the number of decedents from FY04 Estate cases worked (2,734), 82 liens may be collected annually. Assuming the average value of the resident's property is $12,195, the potential recovery is $1,000,000.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 5—Nonemergency Medical Transportation Services

PROPOSED RULE

13 CSR 70-5.010 Nonemergency Medical Transportation (NEMT) Services

PURPOSE: This rule establishes the criteria by which the medical assistance program (Medicaid) reimburses expenses for nonemergency medically necessary transportation if a recipient does not have access to transportation services that are available free of charge.

(1) The Missouri Medical Assistance program (Medicaid) or its contractor reimburses eligible recipients or nonemergency medical transportation (NEMT) providers for medically necessary transportation only if a recipient does not have access to transportation services that are available free of charge.

(A) The recipient must have an appointment for any medical treatment that is approved by the Division of Medical Services.

(B) Alternative transportation services that may be provided free of charge include volunteers, relatives, designated legal representative, individual involved in the resident's care, or transportation services provided by nursing facilities or other residential centers. Recipients must certify in writing that they do not have access to free transportation.

(2) Medicaid eligible residents of a nursing facility are not provided nonemergency transportation services by the Medicaid Nonemergency Transportation Program. Nursing facilities must provide nonemergency transportation to meet the medical needs of the resident, for example, visits to physicians or other medical providers.

(3) Nonemergency medical transportation is not available to a pharmacy.

(4) Medicaid reimburses the most appropriate and least costly transportation alternative suitable for the recipient's medical condition. If a recipient can use private vehicles or less costly public transportation, those alternatives must be used before recipients can use more expensive transportation alternatives.

AUTHORITY: section 208.201, RSMo 2000. Original rule filed May 16, 2005.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Office of the Director, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. If to be hand-delivered, comments must be brought to the Division of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 73—Board of Nursing Home Administrators
Chapter 2—General Rules

PROPOSED AMENDMENT

19 CSR 73-2.050 Renewal of Licenses. The board proposes to amend sections (2) and (3), add a new section (4), and renumber sections (4) and (5).

PURPOSE: This proposed amendment revises the license renewal auditing process, removes the requirement for prior approval on programs held in another state, and increases the number of clock hours awarded for serving as a preceptor.

(2) Licensees seeking renewal shall, during the month of May of each year, file an application for renewal on a form furnished by the board, and shall submit a renewal fee of fifty dollars ($50) made payable to the Department of Health and Senior Services. **Information provided in the application shall be given under oath and include evidence that the licensee has completed, during the reporting period, twenty (20) clock hours of board-approved continuing education. A minimum of five (5) clock hours must be in patient-care related offerings, as defined in 19 CSR 73-2.031(2)(A)–(F). The reporting period will cover fifteen (15) months that begins on April 1, of the preceding licensure year and ends on June 30, of the current licensure year. Continuing education hours earned at a single program cannot be split or used to renew in two (2) different reporting periods.**

(3) *[As a requirement for renewal of license, a licensee shall provide the board, on the annual application form for license renewal, satisfactory evidence of twenty (20) clock hours of board-approved continuing education obtained during the current licensure year or carried from the preceding year. A minimum of five (5) clock hours must be in patient-care related offerings, as defined in 19 CSR 73-2.031(2)(A)–(F) and must be obtained during the current licensure year.]* **Licensees must maintain proof of having completed the number of continuing education hours claimed at the time of renewal and shall, upon request of the board, make that proof available for audit to verify completion of the number and validity of hours claimed. Documentation to prove completion of continuing education hours must be maintained by each licensee for four (4) years from the last day of the licensure year in which the hours were earned.**

(A) A minimum of fifteen (15) clock hours toward the twenty (20) required shall be obtained through attendance at board-approved continuing education programs or academic courses, as defined in 19 CSR 73-2.031(2)(A)–(K), and must meet the following criteria:

1. Be *[prior]* approved by the board. In the case of academic courses, the licensee must submit a course description from the college for board review. A maximum of five (5) clock hours per semester hour may be approved by the board. Upon successful completion of the course (grade of "C" or above), an official *[copy of the]* **transcript or** grade report must be submitted to the board office**, upon request,** as verification of course completion;

2. Be offered by a registered training agency approved by the board or a single offering provider (as outlined in 19 CSR 73-2.060);

3. *[Programs held out-of-state, may be considered for prior approval by the board upon submission of the following information:*

A. Evidence that the program has been] **Be** approved by another state licensure board for nursing home administrators or by the National Continuing Education Review Service (NCERS) under the National Association of Boards (NAB); *[and*

B. A brochure or other detailed information from the program which must include: offering title, date and location; program objectives; speaker credentials; and a detailed agenda.]

(B) A maximum of five (5) clock hours toward the twenty (20) required may be obtained as follows:

1. For the purposes of this subsection, the following definitions shall apply:

A. Referred publication—a publication that undergoes an anonymous review process that determines whether or not the article will be published; and

B. National health-care publication—a publication that is—

(I) Published by a health-care association whose mission statement/bylaws indicate its scope is national;

(II) Mailed nationwide; and

(III) Addressing content contained within the long-term care core of knowledge outlined in 19 CSR 73-2.031(2)(A)–(K);

2. Publishing health-care related articles of at least fifteen hundred (1,500) words shall be granted—

A. Five (5) clock hours if article appears in a national health-care referred publication;

B. Four (4) clock hours if article appears in a regional health-care referred publication;

C. Three (3) clock hours if article appears in a state health-care referred publication;

D. Two (2) clock hours if article appears in a national health-care publication; and

E. One (1) clock hour if article is published.

3. Serving as a registered preceptor for an applicant who has been required by the board to complete an internship as described in 19 CSR 73-2.031. One (1) clock hour per full month as a preceptor shall be granted with a maximum of *[five (5)]* **ten (10)** clock hours per internship; and

4. An administrator lecturing at a board-approved seminar may receive credit equal to each hour or quarter hour of presentation time with a maximum of three (3) hours credit earned per licensure year. This credit may be in addition to actual hours of attendance at the seminar but credit shall be granted for only one (1) presentation of the same seminar

[(E) Licensees making application for renewal of license shall be responsible for filing evidence of continuing education clock hours with the executive secretary BEFORE the renewal application is approved by the board. The evidence submitted may be subject to audit and review by the board and additional documentation may be requested. To facilitate submission of any additional evidence to the board prior to expiration of licenses June 30, all renewal forms must be completed and received by the executive secretary prior to May 30. Information provided in the application shall be given under oath.

(F) Up to a maximum of fifteen (15) excess clock hours from subsection (2)(A), of continuing education may be carried forward to apply toward the renewal of license in the following year. However, the five (5) clock hours required in patient-care related offerings described in section (2) of this rule MUST be applied in the current year. Any excess hours will NOT be used to meet the next year's requirement of five (5) clock hours in patient-care related offerings.]

(4) The board shall annually select on a random basis at least five percent (5%) of the licensees applying for renewal to have their claims of continuing education hours audited for compliance with board requirements. A licensee will be notified by mail when a renewal application has been selected for audit and will have up to thirty (30) days to provide copies of all certificates of attendance and other documentation supporting the continuing education clock hours claimed on the renewal application. Nothing in this section shall prevent the board from requiring any individual licensee to provide evidence satisfactory to the board of having completed the continuing education hours required for license renewal. Failure to provide proof of continuing education hours as reported on the renewal application or submission of falsified records can be cause for discipline pursuant to section 344.050.2., RSMo.

*[(4)]***(5)** If an incomplete application is received by the board prior to May 30, the board shall grant the licensee a thirty (30)-day extension if needed effective May 31. If an incomplete application is received by the board between May 31 and June 30, the board shall grant the licensee a thirty (30)-day extension, if needed, effective the date the incomplete application is received. An incomplete application shall not include an application that lacks completion of the continuing education requirements prior to June 30. The licensee shall submit a completed application within the thirty (30)-day period or the board may refuse to renew the license. The notarized renewal application, fee and supporting documentation must all be submitted to the board office prior to June 30 to avoid the late penalty fee of twenty-five dollars ($25).

[(5)] **(6)** When the required information, documentation and fee are received and approved by the board within the specified time period, the board shall issue the annual license.

AUTHORITY: section 344.070, RSMo 2000. This rule was previously filed as 13 CSR 73-2.050. Original rule filed May 13, 1980, effective Aug. 11, 1980. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed May 16, 2005.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Nursing Home Administrators, Diana Love, Executive Secretary, PO Box 570, 912 Wildwood, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE
Division 400—Life, Annuities and Health
Chapter 3—Medicare Supplement Insurance

PROPOSED AMENDMENT

20 CSR 400-3.650 Medicare Supplement Insurance Minimum Standards Act. The department is amending sections (1)–(10), (12)–(16), (18) and (19) of this rule. The department is also amending Appendix A, Appendix B and Appendix C of this rule. The department is deleting section (23) of this rule. This amendment also replaces a portion of the form referred to in paragraph (15)(C)4., which is found on pages 59–60 of 20 CSR 400-3 as published in the *Code of State Regulations*.

PURPOSE: This amendment changes the terms "agent" and "broker" to "insurance producer," and also implements changes necessary to remain consistent with minimum federal standards applicable to Medicare Supplement Insurance.

(1) Applicability and Scope.

(C) All forms printed with this rule are included herein.

(2) Definitions. For purposes of this rule—

(B) "Bankruptcy" means when a Medicare*[+ Choice]***Advantage** organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state;

(J) "Insurance producer" means a person required to be licensed under section 375.012(6), *Revised Statutes of Missouri*, to sell, solicit or negotiate insurance;

*[(J)]***(K)** "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates;

*[(K)]***(L)** "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended;

*[(L)]***(M)** "Medicare*[+Choice]***Advantage** plan" means a plan of coverage for health benefits under Medicare Part C as defined in section 1859 found in Title IV, Subtitle A, Chapter 1 of P.L. 105-33, and includes:

1. Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

2. Medical savings account plans coupled with a contribution into a Medicare*[+Choice]***Advantage** medical savings account; and

3. Medicare*[+Choice]***Advantage** private fee-for-service plans;

*[(M)]***(N)** "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and health services corporations or health maintenance organizations, other than a policy issued pursuant to a contract under section 1876 of the federal Social Security Act (42 U.S.C. section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare*[;]*. **"Medicare supplement policy" does not include MedicareAdvantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCCP) that provides benefits pursuant to an agreement under section 1833(a)(1)(A) of the Social Security Act;**

*[(N)]***(O)** "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer;

*[(O)]***(P)** "Pre-standardized Medicare supplement plan" means a Medicare supplement plan issued prior to July 30, 1992;

*[(P)]***(Q)** "Qualified actuary" means a member of the American Academy of Actuaries;

*[(Q)]***(R)** "Standardized Medicare Supplement Plan" means a Medicare supplement plan issued after July 30, 1992; and

*[(R)]***(S)** "Secretary" means the Secretary of the United States Department of Health and Human Services.

(3) Policy Definitions and Terms. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms which conform to the requirements of this section.

(D) "Health care expenses" means**, for purposes of section (12),** expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. *[Expenses shall not include:*

1. Home office and overhead costs;

2. Advertising costs;

3. Commissions and other acquisition costs;

4. Taxes;

5. Capital costs;

6. Administrative costs; and

7. Claims processing costs.]

(G) "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare **Parts A and B**, to the extent recognized as reasonable and medically necessary by Medicare.

(4) Policy Provisions.

(D)

1. Subject to paragraphs (5)(A)4., 5. and 7. and (6)(A)4. and 5., a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006, shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

2. A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

3. After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

A. The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan and;

B. Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

(5) Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to July 30, 1992. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(A) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this rule.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

4. A "noncancelable," "guaranteed renewable," or "noncancelable and guaranteed renewable" Medicare supplement policy shall not—

A. Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

B. Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

5.

A. Except as authorized by the director, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

B. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subparagraph D. of this paragraph, the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

(I) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(II) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in subsection (6)(B) of this rule.

C. If membership in a group is terminated, the issuer shall—

(I) Offer the certificate holder the conversion opportunities described in subparagraph 5.B. of this subsection; or

(II) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

D. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. **Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.**

7. If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

(6) Benefit Standards for Policies or Certificates Issued or Delivered on or After July 30, 1992. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 30, 1992. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(A) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this rule.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

4. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

5. Each Medicare supplement policy shall be guaranteed renewable.

A. The issuer shall not cancel or nonrenew the policy solely on the grounds of health status of the individual.

B. The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

C. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subparagraph (6)(A)5.E., the issuer shall offer certificate holders an individual Medicare supplement policy which at the option of the certificate holder:

(I) Provides for continuation of the benefits contained in the group policy; or

(II) Provides for benefits that otherwise meet the requirements of this subsection.

D. If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall—

(I) Offer the certificate holder the conversion opportunity described in subparagraph (6)(A)5.C.; or

(II) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

E. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

F. If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. **Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.**

7.

A. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period not to exceed twenty-four (24) months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

B. If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted effective as of the date of termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

C. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal rule) at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan (as defined in section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

*[C.]***D.** Reinstitution of coverages*[—]***as described in subparagraphs (6)(A)7.B. and (6)(A)7.C.:**

(I) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(II) Shall provide for **resumption of** coverage which is substantially equivalent to coverage in effect before the date of suspension*[;]*. **If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension;** and

(III) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(B) Standards for Basic (Core) Benefits Common to *[All Benefit Plans]* **Benefit Plans A–J**. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period.

2. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

3. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of **one hundred percent (100%) of** the Medicare Part A eligible expenses for hospitalization paid at the *[diagnostic related group (DRG) day outlier per diem]* **applicable prospective payment system (PPS) rate,** or other appropriate **Medicare** standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. **The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.**

4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

5. Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(C) Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by section (7) of this rule.

1. Medicare Part A Deductible. Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

2. Skilled Nursing Facility Care. Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

3. Medicare Part B Deductible. Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

4. Eighty Percent (80%) of the Medicare Part B Excess Charges. Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

5. One Hundred Percent (100%) of the Medicare Part B Excess Charges. Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

6. Basic Outpatient Prescription Drug Benefit. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar*[s]* ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare. **The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.**

7. Extended Outpatient Prescription Drug Benefit*[:]*. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar*[s]* ($250) calendar year deductible to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare. **The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.**

8. Medically Necessary Emergency Care in a Foreign Country. Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

9. Preventive Medical Care Benefit. Coverage for the following preventive health services*[:]* **not covered by Medicare:**

A. An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph B. and patient education to address preventive health care measures;

[B. Any one (1) or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(I) Fecal occult blood test or digital rectal examination, or both;

(II) Mammogram;

(III) Dipstick urinalysis for hematuria, bacteriuria and proteinuria;

(IV) Pure tone (air only) hearing screening test, administered or ordered by a physician;

(V) Serum cholesterol screening (every five (5) years);

(VI) Thyroid function test;

(VII) Diabetes screening;]

B. Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician;

C. Influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster as medically appropriate; **and**

[D. Any other tests or preventive measures determined appropriate by the attending physician; and]

*[E.]***D.** Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars ($120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

10. At-Home Recovery Benefit. Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

A. For purposes of this benefit, the following definitions shall apply:

(I) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;

(II) "Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;

(III) "Home" shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence; and

(IV) "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four (24)-hour period of services provided by a care provider is one (1) visit.

B. Coverage Requirements and Limitations.

(I) At-home recovery services provided must be primarily services which assist in activities of daily living.

(II) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(III) Coverage is limited to—

(a) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment;

(b) The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit;

(c) One thousand six hundred dollars ($1,600) per calendar year;

(d) Seven (7) visits in any one (1) week;

(e) Care furnished on a visiting basis in the insured's home;

(f) Services provided by a care provider as defined in this section;

(g) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(h) At-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight (8) weeks after the service date of the last Medicare-approved home health care visit.

C. Coverage is excluded for—

(I) Home care visits paid for by Medicare or other government programs; and

(II) Care provided by family members, unpaid volunteers or providers who are not care providers.

11. New or Innovative Benefits. An issuer may, with the prior approval of the director, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. **After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.**

(D) Standards for Plans K and L.

1. Standardized Medicare supplement benefit plan "K" shall consist of the following:

A. Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;

B. Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;

C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

D. Medicare Part A deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (6)(D)1.J.;

E. Skilled nursing facility care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph (6)(D)1.J.;

F. Hospice care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph (6)(D)1.J.;

G. Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal rules) unless replaced in accordance with federal rules until the out-of-pocket limitation is met as described in subparagraph (6)(D)1.J.;

H. Except for coverage provided in subparagraph (6)(D)1.I. below, coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph (6)(D)1.J. below;

I. Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

J. Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars ($4,000) in 2006, indexed each year by the appropriate inflation adjustments specified by the secretary of the U.S. Department of Health and Human Services.

2. Standardized Medicare supplement benefit plan "L" shall consist of the following:

A. The benefits described in subparagraphs (6)(D)1.A., B., C., and I;

B. The benefit described in subparagraphs (6)(D)1.D., E., F., G., and H., but substituting seventy-five percent (75%) for fifty percent (50%); and

C. The benefit described in subparagraph (6)(D)1.J., but substituting two thousand dollars ($2,000) for four thousand dollars ($4,000).

(7) Standard Medicare Supplement Benefit Plans.

(A) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in subsections (6)(B) **and (6)(C)** of this rule.

(C) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through *["J"]* **"L"** listed in this section and conform to the definitions in section (3) of this rule. Each benefit shall be structured in accordance with the format provided in subsections (6)(B)*[and]*, (6)(C)**, and (6)(D)** and list the benefits in the order shown in this section. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

(E) Make-Up of Benefit Plans.

1. Standardized Medicare supplement benefit plan "A" shall be limited to the basic (core) benefits common to all benefit plans, as defined in subsection (6)(B) of this rule.

2. Standardized Medicare supplement benefit plan "B" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible as defined in paragraph (6)(C)1.

3. Standardized Medicare supplement benefit plan "C" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in paragraphs (6)(C)1., 2., 3. and 8. respectively.

4. Standardized Medicare supplement benefit plan "D" shall include only the following: The core benefit (as defined in subsection (6)(B) of this rule), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in foreign country and the at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 8. and 10. respectively.

5. Standardized Medicare supplement benefit plan "E" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in paragraphs (6)(C)1., 2., 8. and 9. respectively.

6. Standardized Medicare supplement benefit plan "F" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (6)(C)1., 2., 3., 5. and 8. respectively.

7. Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (6)(C)1., 2., 3., 5., and 8., respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible shall be one thousand five hundred dollars ($1,500) for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12)-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

8. Standardized Medicare supplement benefit plan "G" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 4., 8. and 10. respectively.

9. Standardized Medicare supplement benefit plan "H" shall consist of only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in paragraphs (6)(C)1., 2., 6. and 8. respectively. **The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.**

10. Standardized Medicare supplement benefit plan "I" shall consist of only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in paragraphs (6)*[(B)]***(C)**1., 2., 5., 6., 8. and 10. respectively. **The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.**

11. Standardized Medicare supplement benefit plan "J" shall consist of only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 3., 5., 7., 8., 9. and 10. respectively. **The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.**

12. Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: one hundred percent (100%) of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in subsection (6)(B) of this rule, plus the Medicare part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 3., 5., 7., 8., 9. and 10. respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be fifteen hundred dollars ($1,500) for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12)-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10). **The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.**

(F) Make-up of two (2) Medicare supplement plans mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

1. Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in paragraph (6)(D)1.

2. Standardized Medicare supplement plan "L" shall consist only of those benefits described in paragraph (6)(D)2.

(8) Medicare Select Policies and Certificates. This section shall apply to Medicare Select policies and certificates, as defined in this section.

(I) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

1. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with—

A. Other Medicare supplement policies or certificates offered by the issuer; and

B. Other Medicare Select policies or certificates;

2. A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers;

3. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized*[;]*. **Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans "K" and "L";**

4. A description of coverage for emergency and urgently needed care and other out-of-service area coverage;

5. A description of limitations on referrals to restricted network providers and to other providers;

6. A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer; and

7. A description of the Medicare Select issuer's quality assurance program and grievance procedure.

(M)

1. At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

2. For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, *[coverage for prescription drugs,]* coverage for at-home recovery services or coverage for Part B excess charges.

(N) Medicare Select policies and certificates shall provide for continuation of coverage in the event the secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

1. Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

2. For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, *[coverage for prescription drugs,]* coverage for at-home recovery services or coverage for Part B excess charges.

(9) Open Enrollment.

(A) No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6)-month period beginning with the first day of the first month in which the applicant is both sixty-five (65) years of age or older and is enrolled for benefits under Medicare Part B.

1. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

(E) No issuer required by subsection (B) of this section to issue policies or certificates of Medicare supplement insurance shall discriminate as to rates, between the rates charged to persons enrolled under subsection (B) of this section and the average rates charged for participation in that policy form number or certificate form number by persons enrolled in Medicare Part B by reason of age, or discriminate between persons entitled to enroll in the policy form number or certificate form number under subsection (B) of this section and other enrollees in the policy form number or certificate form number in other terms or conditions of the plan, policy form number, or certificate form number.

1. An issuer must demonstrate compliance with this section for each plan, type, and form level permitted under subsection (13)*[(C)]***(D)** by either—

A. Charging a premium rate for disabled persons that does not exceed the lowest available aged premium rate for that plan, type, and form level; or

B. Charging a premium rate for disabled persons that does not exceed the "weighted average aged premium rate" for that plan, type, and form level, and providing, at the time of each rate filing, its calculation of the "weighted average aged premium rate" for each plan, type, and form level.

2. The "weighted average aged premium rate" is determined by—

A. First multiplying the premium rate (calculated prior to modal, area, and other factors) for each age band, age sixty-five (65) and over, by the number of Missouri insureds in-force in that age band to arrive at the total Missouri premium for each age band age sixty-five (65) and over; and

B. Then calculating the sum of the Missouri premium for all age bands age sixty-five (65) and over to arrive at the total Missouri premium for all age bands age sixty-five (65) and over; and

C. Then calculating the sum of the Missouri insureds*[-]*/in-force for all age bands age sixty-five (65) and over to arrive at the total number of Missouri insureds in-force for all age bands age sixty-five (65) and over; and

D. Then dividing the total Missouri premium for all age bands age sixty-five (65) and over by the total number of Missouri insureds in-force for all age bands, age sixty-five (65) and over to determine the weighted average aged premium rate.

3. Modal, area, and other factors may be added to the disabled premium.

(H) No Medicare supplement carrier shall, directly or indirectly enter into any contract, agreement or arrangement with an *[agent or broker]* **insurance producer** that provides for or results in the compensation paid to an *[agent or broker]* **insurance producer** for the sale of a Medicare supplement policy or certificate to be varied because of the age, health status, claims experience, receipt of health care or medical condition of an applicant eligible by reason of subsection (B) of this section for Medicare supplement insurance.

(I) A Medicare supplement carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an *[agent or broker]* **insurance producer**, if any, for the sale, during the open enrollment periods described in subsection (B) of this section, of a Medicare supplement insurance policy or certificate.

(J) No Medicare supplement insurance carrier shall terminate, fail to renew or limit its contract or agreement of representation with an *[agent or broker]* **insurance producer** for any reason related to the age, health status, claims experience, receipt of health care or medical condition of an applicant, eligible by reason of subsection (B) of this section for Medicare supplement insurance, placed by the *[agent or broker]* **insurance producer** with the Medicare supplement insurance carrier.

(10) Guaranteed Issue for Eligible Persons.

(A) Guaranteed Issue.

1. Eligible persons are those individuals described in subsection (B) of this section who *[apply to enroll under the policy not later than sixty-three (63) days after the date of the termination of enrollment described in subsection (B) of this section,]* **seek to enroll under the policy during the period specified in subsection (C) of this section,** and who submit evidence*[, acceptable to the director,]* of the date of termination *[or disenrollment]***, disenrollment, or Medicare Part D enrollment** with the application for a Medicare supplement policy.

2. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection *[(C)]***(E)** of this section that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(B) Eligible Persons. An eligible person is an individual described in any of the following paragraphs:

1. The individual is enrolled under an employee welfare benefit plan **that provides health benefits that supplement the benefits under Medicare**; and the plan terminates, or the plan ceases to provide *[substantial health benefits to the individual either because the plan is modified or amended, or because the plan terminates, or because the individual leaves the plan]* **all such supplemental health benefits to the individual**;

2. The individual is enrolled with a Medicare*[+Choice]* **Advantage** organization under a Medicare*[+Choice]***Advantage** plan under Part C of Medicare, and any of the following circumstances apply, **or the individual is sixty-five (65) years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a MedicareAdvantage plan**:

A. The organization's or plan's certification has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

B. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or because the plan is terminated for all individuals within a residence area or because of another change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856);

C. The individual demonstrates, in accordance with guidelines established by the secretary, that—

(I) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(II) The organization, *[or agent]* **insurance producer,** or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

D. The individual meets such other exceptional conditions as the secretary may provide;

3.

A. The individual is enrolled with—

(I) An eligible organization under a contract under section 1876 (Medicare risk or cost);

(II) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(III) An organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan); or

(IV) An organization under a Medicare Select Policy; and

B. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (10)(B)2.;

4. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because—

A.

(I) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(II) Of other involuntary termination of coverage or enrollment under the policy;

B. The issuer of the policy substantially violated a material provision of the policy; or

C. The issuer, *[or an agent]* **insurance producer,** or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

5.

A. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare*[+Choice]***Advantage** organization under a Medicare*[+Choice]***Advantage** plan under Part C of Medicare, any eligible organization under a contract under section 1876 (Medicare risk or cost), any similar organization operating under demonstration project authority, **any PACE provider under section 1894 of the Social Security Act,** an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan), or a Medicare Select policy; and

B. The subsequent enrollment under subparagraph (10)(B)5.A. is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or

6. The individual, upon first becoming eligible for benefits under Part A of Medicare *[and enrolling in Medicare Part B]*, enrolls in a Medicare*[+Choice]***Advantage** plan under Part C of Medicare, **or with a PACE provider under section 1894 of the Social Security Act,** and disenrolls from the plan **or program** by not later than twelve (12) months after the effective date of enrollment; and

7. The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in paragraph (E)4. of this section; and

*[7.]***8.** Any individual who terminates Medicare supplement coverage within thirty (30) days of the annual policy anniversary.

(C) Guarantee Issue Time Periods.

1. In the case of an individual described in paragraph (B)1. of this section, the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

2. In the case of an individual described in paragraph (B)2., (B)3., (B)5. or (B)6. of this section whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends

sixty-three (63) days after the date the applicable coverage was terminated;

3. In the case of an individual described in subparagraph (B)4.A. of this section, the guarantee issue period begins on the earlier of: (i) the date that individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage was terminated;

4. In the case of an individual described in paragraph (B)2., subparagraph (B)4.B., (B)4.C., paragraph (B)5. or (B)6., of this section who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;

5. In the case of an individual described in paragraph (B)7. of this section, the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty (60)-day period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

6. In the case of an individual described in subsection (B) of this section but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment or the effective date of the loss of coverage under the group health plan and ends on the date that is sixty-three (63) days after the effective date.

(D) Extended Medigap Access for Interrupted Trial Periods.

1. In the case of an individual described in paragraph (B)5. of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in subparagraph (B)5.A. of this section is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (10)(B)6.; and

2. In the case of an individual described in paragraph (B)6. of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in paragraph (B)6. of this section is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (10)(B)6.; and

3. For purposes of paragraphs (B)5. and (B)6. of this section, no enrollment of an individual with an organization or provider described in subparagraph (B)5.A. of this section, or with a plan or in a program described in paragraph (B)6. of this section, may be deemed to be an initial enrollment under this paragraph after the two (2)-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

*[(C)]***(E)** Products to Which Eligible Persons Are Entitled. The Medicare supplement policy to which eligible persons are entitled under—

1. Paragraphs (10)(B)1., 2., 3. and 4. is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F **(including F with a high deductible), K or L** offered by any issuer;

[2. Paragraph (10)(B)5. is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in paragraph (C)1. of this section;]

A. Subject to subparagraph B., paragraph (10)(B)5. is the same Medicare supplement policy in which the individual was most recently enrolled, if available from the same issuer, or, if not so available, a policy described in paragraph 1. of this subsection;

B. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this subparagraph is:

(I) The policy available from the same issuer but modified to remove the outpatient prescription drug coverage; or

(II) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer;

*[3.]***2.** Paragraph(10)(B)6. shall include any Medicare supplement policy offered by any issuer; *[and]*

3. Paragraph (10)(B)7. is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage; and

4. Paragraph (10)(B)*[7.]***8.** shall include any Medicare supplement policy offered by any issuer but only a policy of the same plan as the coverage in which the individual was most recently enrolled.

*[(D)]***(F)** Notification Provisions.

1. At the time of an event described in subsection (B) of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (A). Such notice shall be communicated contemporaneously with the notification of termination.

2. At the time of an event described in subsection (B) of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (A) of this section. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.

(12) Loss Ratio Standards and Refund or Credit of Premium.

(A) Loss Ratio Standards.

1.

A. A Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form the higher of the originally filed anticipated loss ratio or—

(I) At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

(II) At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies.

B. The ratios specified in this subsection shall be calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. **Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:**

(I) Home office and overhead costs;
(II) Advertising costs;
(III) Commissions and other acquisition costs;
(IV) Taxes;
(V) Capital costs;
(VI) Administrative costs; and
(VII) Claims processing costs.

2. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards (future loss ratio).

3. For purposes of applying paragraph (A)1. of this section and paragraph *[(C)]***(D)**3. of section (13) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

4. For policies issued prior to July 30, 1992, expected claims in relation to premiums shall meet—

A. The originally filed anticipated loss ratio when combined with the actual experience since inception (the lifetime loss ratio);

B. The appropriate loss ratio requirement from parts (A)1.A.(I) and (II) of this section when combined with actual experience beginning with *[either April 28, 1996, or January 1, 1996]* **January 1, 2006** to date; and

C. The appropriate loss ratio requirement from parts (A)1.A.(I) and (II) of this section over the entire future period for which the rates are computed to provide coverage.

(B) Refund or Credit Calculation.

1. An issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

2. If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

3. For the purposes of this section, policies or certificates issued prior to July 30, 1992, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after *[April 28, 1996]* **January 1, 2006**. The first report shall be due by May 31, *[1998]* **2008**.

4. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a *de minimis* level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen (13)-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(13) Filing and Approval of Policies and Certificates and Premium Rates.

(B) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the director in the state in which the policy or certificate was issued.

*[(B)]***(C)** An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the director in accordance with the filing requirements and procedures prescribed by the director.

*[(C)]***(D)**

1. Except as provided in paragraph 2. of this subsection, an issuer shall not file for approval more than one (1) form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

2. An issuer may offer, with the approval of the director, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one (1) for each of the following cases:

A. The inclusion of new or innovative benefits;

B. The addition of either direct response or *[agent]* **insurance producer** marketing methods;

C. The addition of either guaranteed issue or underwritten coverage; and

D. The offering of coverage to individuals eligible for Medicare by reason of disability.

3. For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

*[(D)]***(E)**

1. Except as provided in subparagraph 1.A. of this subsection, an issuer shall continue to make available for purchase any policy form or certificate form issued after April 8, 1993, that has been approved by the director. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

A. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the director in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the director, the issuer shall no longer offer for sale the policy form or certificate form in this state.

B. An issuer that discontinues the availability of a policy form or certificate form pursuant to subparagraph 1.A. of this subsection shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate.

2. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

3. Effect of change in rating structure or methodology.

A. A change in the rating structure or methodology includes, but is not limited to:

(I) A change between community rating, issue-age rating, and attained-age rating;

(II) A change in class structure (e.g., one class v. smoker/non-smoker class, unisex v. male/female classes); and

(III) A change between rating for each age v. age-banded rates.

B. A change in the rating structure or methodology shall be considered a discontinuance under paragraph 1. of this subsection unless the issuer complies with the following requirements:

(I) The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates; and

(II) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. Such actuarially equivalent policies or certificates shall be combined for filing purposes under

paragraph (13)*[(G)]***(H)**11. The director may approve a change to the differential which is in the public interest.

C. Notwithstanding subparagraph B. of this paragraph, where an issuer changes a rating structure or methodology and rates calculated under the new methodology are not actuarially equivalent to the old rates, the change in rating structure or methodology will be considered a discontinuance under subparagraph (13)*[(D)]***(E)**1.A. The actuarial equivalency of rates must be determined by a comparison of weighted average premium rate under the old and the new methodology, except in the case of a change between attained-age and issue-age rating where the actuarial equivalency of the rates will be determined from a comparison of actuarial present value of lifetime premiums by age or age-band.

*[(E)]***(F)**

1. Except as provided in paragraph *[(E)]***(F)**2. of this section, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in section (12) of this rule.

2. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

*[(F)]***(G)**

1. An issuer shall not present for filing or approval a rate structure for its Medicare supplement policies or certificates issued after January 1, 2000, based upon attained-age rating as a structure or methodology. Notwithstanding, an issuer may continue in-force policies and certificates issued prior to January 1, 2000.

2. Where an issuer files for approval of a rate structure for policy forms or certificate forms which reflects a change in methodology from attained age to issue age, the issuer must demonstrate the actuarial equivalency of the rates proposed with the previously approved attained-age rates as required by paragraph (13)*[(D)]***(E)**3. If the policy forms or certificate forms were at any time approved by the director under an issue age methodology, the issuer must use the most recently approved issue age rate schedule as its proposed rate schedule for the policy forms or certificate forms and need make no further showing of actuarial equivalency under (13)*[(D)]***(E)**3.

*[(G)]***(H)** Filing requirements and procedures for change of Medicare supplement insurance premium rate and for annual filing of premium rates.

1. When an issuer files for approval of annual premium rates for a plan under subsection (12)(C) or a change of premium rates for a plan under subsection (13)*[(B)]***(C)**, the following documentation must be provided to the director as part of the rate filing in addition to any other documentation required by law or regulation:

A. A completed Medicare Supplement Rate Filing Document (Missouri Form 375-0065, revised 10/98), which *[is incorporated herein by reference]* **can be accessed at the department's website at www.insurance.mo.gov**;

B. An actuarial memorandum supporting the rating schedule;

C. A report of durational experience (for standardized Medicare supplement plans only);

D. A projection correctly derived from reasonable assumptions;

E. A clear statement of all of the assumptions used to prepare the rate filing, including the source of trend;

F. All formulas used to prepare the projection except for formulas which can be ascertained from a cursory inspection of the projection itself; and

G. The issuer's current rate schedule and the proposed rate schedule for this state, including rates for disabled persons, if any, and all rating factors, including, but not limited to: area; smoker/non-smoker; standard/substandard.

2. The report of durational experience must contain for each calendar year of issue the following data by duration: incurred claims and earned premium; resultant loss ratio; and life-years. The durational split may be either by policy or certificate duration, calendar duration or calendar year of experience within each calendar year of issue.

3. The projection must—

A. State the incurred claims and earned premium, resultant loss ratio and corresponding life-years for each of the preceding calendar years beginning with the year in which the policy or certificate was first issued and must include the total for each category (incurred claims and earned premium, resultant loss ratio, and corresponding life-years) for all preceding calendar years;

B. State the projected incurred claims and projected earned premium, resultant loss ratios and corresponding life-years for at least each of the ten (10) calendar years subsequent to the rate filing and must include the total for each category (projected incurred claims and projected earned premium, resultant loss ratio, and corresponding life-years) for all projected calendar years;

C. Include a calculation of the sums of the combined total figures reported under subparagraph A. of this paragraph and those reported under subparagraph B. of this paragraph; and

D. Include, for pre-standardized Medicare supplement plans, the respective totals of the incurred claims and earned premium, resultant loss ratio, and corresponding life-years for the period beginning April 28, 1996, or alternatively, January 1, 1996, through the end of the projection period described in subparagraph B. of this paragraph.

4. Where assumptions include interest, the totals for incurred claims accumulated/discounted with interest, earned premium accumulated/discounted with interest, and the resultant loss ratio must also be shown in all parts of the projection described in paragraph *[(G)]***(H)**3. of this section.

5. Both the report of durational experience and the projection must report Missouri and national data with respect to incurred claims, earned premium, loss ratio, and life-years. The projection must also report this information both with and without the rate change requested.

6. The issuer must specify whether the figures reported as incurred claims were determined by adding claims paid to unpaid claims reserves or by the actual runoff of claims. The method of determining the incurred claims must be consistent throughout the filing and supporting documentation.

7. Changes in active life reserves or claims expenses may not be included in incurred claims in the rate filing or any supplemental documentation.

8. For purposes of this section, "incurred claims" means the dollar amount of incurred claims.

9. Earned premium reported in the rate filing or any supporting documentation must include modal loadings and policy fees. An adjustment for premium refunds, if any, must also be made to earned premium and the details of the adjustment must be provided to the director with the filing. Changes in active life reserves may not be included in earned premium.

10. Life-years reported in a rate filing or supplemental documentation must be calculated in the same manner as for refund calculations.

11. Rate filings for each plan, type, and form level permitted under subsection (13)*[(C)]***(D)** for standardized Medicare supplement plans marketed after June 30, 1998, must demonstrate compliance with the requirements of subsection (9)(E). The "weighted average aged premium," must be recalculated for each filing using current data, unless the issuer demonstrates compliance under subparagraph (9)(E)1.A. The figure used in the calculation for the total number of insureds in-force for all age bands, age sixty-five (65) and over, must be the same as the figure reported on Missouri Form 375-0065 for the "Number of Missouri Aged Insureds."

12. For standardized Medicare supplement plans, the Medicare Supplement Rate Filing Document, the report of durational experience, and the projection must be provided separately for each plan, type, and form level permitted under subsection (13)*[(C)]***(D)**.

13. For pre-standardized Medicare supplement rate plans, the information contained in the Medicare Supplement Rate Filing Document and projection may be pooled within a type.

14. The rates, rating schedule and supporting documentation required to be filed under subsection *[(G)]***(H)** of this section as part of a rate filing and all supplementary documentation in connection with the rate filing must be accompanied by the certification of a qualified actuary that to the best of the actuary's knowledge and judgment, the following items are true with respect to the documentation submitted:

A. The assumptions present the actuary's best judgment as to the expected value for each assumption and are consistent with the issuer's business plan at the time of the filing;

B. The anticipated lifetime, future, and third-year loss ratios for the policy form or certificate form for which the rates are filed comply with the loss ratio requirements of subsection (12)(A) for policy forms or certificate forms of its type delivered or issued for delivery in this state;

C. With respect to rate filings concerning pre-standardized plans, the loss ratio for year 1996 (from April 28 or from January 1) through the end of the projection period complies with the loss ratio requirements of subsection (12)(A) for policies or certificates issued prior to July 30, 1992, and delivered or issued for delivery in this state;

D. Where the rate filing concerns a policy or certificate as to which rating methodologies have changed or are presented for approval based on a change in methodology, the percentage differential between the discontinued and subsequent (or new) rates has not changed;

E. All components of the filing, including rates, rating schedules, and supporting documentation, were prepared based on the current standards of practice promulgated by the Actuarial Standards Board;

F. The rate filing, including rates, rating schedule, and supporting documentation, is in compliance with the applicable laws and regulations of this state; and

G. The rates requested are reasonable in relationship to the benefits provided by the policy or certificate.

(14) Permitted Compensation Arrangements.

(A) An issuer or other entity may provide commission or other compensation to an *[agent]* **insurance producer** or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(C) No issuer or other entity shall provide compensation to its *[agents or other producers]* **insurance producers** and no *[agent or]* producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

(15) Required Disclosure Provisions.

(A) General Rules.

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

2. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

3. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

4. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

5. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

6.

A. Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the *[Health Care Financing Administration]* **Centers for Medicare and Medicaid Services (CMS)** and in a type size no smaller than twelve (12)-point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this rule. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

B. For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

(C) MMA Notice Requirements. Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

*[(C)]***(D)** Outline of Coverage Requirements for Medicare Supplement Policies.

1. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant.

2. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than twelve (12)-point type, immediately above the company name: **"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."**

3. The outline of coverage provided to applicants pursuant to this section consists of four (4) parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in

the language and format prescribed below in no less than twelve (12)-point type. All plans A–*[J]***L** shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

4. The following items shall be included in the outline of coverage in the order prescribed below.

PUBLISHER'S NOTE: The forms included with this proposed amendment are printed with the emergency amendment on pages 1231–1271 of this issue of the ***Missouri Register****.*

*[(D)]***(E)** Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

1. Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy**,** a policy issued pursuant to a contract under section 1876 of the Federal Social Security Act (42 U.S.C. 1395 et seq.), disability income policy; or other policy identified in subsection (1)(B) of this rule, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve (12)-point type and shall contain the following language: "THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

2. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in paragraph *[(D)]***(E)**1. of this section shall disclose, using the applicable statement in Appendix C, **included herein,** the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

(16) Requirements for Application Forms and Replacement Coverage.

(A) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant **currently** has *[another]* Medicare supplement, **MedicareAdvantage, Medicaid coverage,** or *[other]* **another** health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and *[agent]* **insurance producer** containing such questions and statements may be used.

Statements:

1. You do not need more than one Medicare supplement policy.

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

4. **If, after purchasing this policy, you become eligible for Medicaid,** *[T]***t**he benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for twenty-four (24) months. You must request this suspension within ninety (90) days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your **suspended Medicare supplement** policy **(or, if that is no longer available, a substantially equivalent policy)** will be reinstituted if requested within ninety (90) days of losing Medicaid eligibility. **If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.**

5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety (90) days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

*[5.]***6.** Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Questions:

[To the best of your knowledge,

1. Do you have another Medicare supplement policy or certificate in force?

A. If so, with which company?

B. If so, do you intend to replace your current Medicare supplement policy with this policy [certificate]?

2. Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?

A. If so, with which company?

B. What kind of policy?

3. Are you covered for medical assistance through the state Medicaid program:

A. As a Specified Low-Income Medicare Beneficiary (SLMB)?

B. As a Qualified Medicare Beneficiary (QMB)?

C. For other Medicaid medical benefits?]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

(Please mark Yes or No below with an "X")

To the best of your knowledge,

(1)

(a) Did you turn age 65 in the last 6 months?

Yes____ No____

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes____ No____

(c) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a "Spend-down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes____ No____

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes____ No____

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes____ No____

(3)

(a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START __/__/__ END __/__/__

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes____ No____

(c) Was this your first time in this type of Medicare plan?

Yes____ No____

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes____ No____

(4)

(a) Do you have another Medicare supplement policy in force?

Yes____ No____

(b) If so, with what company, and what plan do you have [optional for Direct Mailers]?

_____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes____ No____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes____ No____

(a) If so, with what company and what kind of policy?

_____
_____
_____
_____

(b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.

START __/__/__ END __/__/__

(B) *[Agents]* **Insurance producers** shall list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.

2. List policies sold in the past five (5) years which are no longer in force.

(D) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its *[agent]* **insurance producer**, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of the notice signed by the applicant and the *[agent]* **insurance producer**, except where the coverage is sold without an *[agent]* **insurance producer**, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(E) The notice required by subsection (D) above for an issuer shall be provided in substantially the following form in no less than twelve (12)-point type:(18) Standards for Marketing.

PUBLISHER'S NOTE: The forms included with this proposed amendment are printed with the emergency amendment on pages 1274–1275 of this issue of the ***Missouri Register****.*

(18) Standards for Marketing.

(A) An issuer, directly or through its producers, shall—

1. Establish marketing procedures to assure that any comparison of policies by its *[agents or other producers]* **insurance producers** will be fair and accurate;

2. Establish marketing procedures to assure excessive insurance is not sold or issued;

3. Display prominently by type, stamp or other appropriate means, on the first page of the policy the following: **"Notice to buyer: This policy may not cover all of your medical expenses."**;

4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance; and

5. Establish auditable procedures for verifying compliance with this subsection (A).

(B) In addition to the practices prohibited in the Unfair Trade Practices Act (sections 375.930 to 375.948, RSMo) and the Unfair Claim Settlement Practices Act (sections 375.1000 to 375.1018, RSMo), the following acts and practices are prohibited:

1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer;

2. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance; and

3. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance *[agent]* **producer** or insurance company.

(19) Appropriateness of Recommended Purchase and Excessive Insurance.

(A) In recommending the purchase or replacement of any Medicare supplement policy or certificate an *[agent]* **insurance producer** shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(C) *[Any sale of Medicare supplement insurance to a person enrolled in a Medicare + Choice plan is prohibited.]* **An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.**

[(23) Effective Date. This rule shall be effective thirty days after publication in the Missouri Code of State Regulations.]

PUBLISHER'S NOTE: Appendix A, Appendix B and Appendix C that are included in this proposed amendment are printed with the emergency amendment on pages 1277–1297 of this issue of the ***Missouri Register****.*

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

AUTHORITY: section[s] 374.045, [376.864.3, 376.864.4, 376.864.5, 376.879 and 376.886, RSMo Supp. 1998 and 376.874, RSMo 1994] ***RSMo 2000****. Original rule filed Oct. 15, 1998, effective June 30, 1999. Emergency amendment filed May 16, 2005, effective June 1, 2005, expires Feb. 2, 2006. Amended: Filed May 16, 2005.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing will be held on this proposed amendment at 10 a.m. on July 20, 2005. The public hearing will be held at the Harry S Truman State Office Building, Room 530, 301 West High Street, Jefferson City, Missouri. Opportunities to be heard at the hearing shall be afforded to any interested person. Interested persons, whether or not heard, may submit a written statement in support of or in opposition to the proposed amendment, until 5:00 p.m. on July 20, 2005. Written statements shall be sent to Stephen R. Gleason, Department of Insurance, PO Box 690, Jefferson City, MO 65102.

SPECIAL NEEDS: If you have any special needs addressed by the Americans With Disabilities Act, please notify us at (573) 751-6798 or (573) 751-2619 at least five (5) working days prior to the hearing.

This section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order of rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted which has been changed from that contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

The agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The ninety (90)-day period during which an agency shall file its order of rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the proposed rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 29—Enhanced Record Exchange Rules

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.040 and 386.250, RSMo 2000, the commission adopts a rule as follows:

4 CSR 240-29.010 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 3, 2005 (30 MoReg 49–50). The section of the proposed rule with changes is reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The public comment period ended February 2, 2005, and the commission received written comments from the staff of the commission and from seven (7) other parties. Three (3) of these commenters generally opposed the rules; the other commenters generally supported the rules. A public hearing was held on February 9, 2005, when the commission heard testimony from the staff of the commission and from eight (8) other witnesses representing six (6) other parties, each of whom had also filed written comments. Two (2) of these parties generally opposed the rules; the other parties generally supported the rules.

COMMENT: A public hearing on this and associated proposed rules was held February 9, 2005, and the public comment period ended February 2, 2005. At the public hearing, Keith Krueger, Deputy General Counsel in General Counsel's Office of the Public Service Commission of Missouri, and William Voight, Rate/Tariff Examination Supervisor of the Public Service Commission of Missouri, provided oral comments and responded to questions from commissioners: Leo J. Bub, appeared as attorney for Southwestern Bell Telephone, LP, Marlon Hines and Joe Murphy provided comments for Southwestern Bell Telephone, LP, and Marlon Hines responded to commissioners questions; John Idoux provided oral comments and responded to commissioner questions for Sprint Missouri, Inc. and Sprint Spectrum, LP d/b/a Sprint PCS; Matt Kohly appeared to respond to any commissioner questions directed to Socket Telecom LLC, XO Communications Services, Inc. or Big River Telephone Company, LLC; Larry Dority of Fischer and Dority, P.C., provided comments and responded to commissioner questions for CenturyTel of Missouri, LLC and Spectra Communications Group, LLC; William R. England, III of Brydon, Swearengen & England P.C., appeared as attorney for and Robert Schoonmaker provided oral comments and responded to commissioner questions for the companies known as the Small Telephone Company Group ("STCG"); and Craig S. Johnson of Andereck, Evans, Milne, Peace and Johnson, LLP, provided oral comments for the companies known as the Missouri Independent Telephone Group ("MITG").

The Staff of the commission; Southwestern Bell Telephone, LP; Sprint Missouri, Inc. and Sprint Spectrum, LP d/b/a Sprint PCS; Socket Telecom LLC, XO Communications Services, Inc. and Big River Telephone Company, LLC, CenturyTel of Missouri, LLC and Spectra Communications Group, LLC; STCG; MITG; VoiceStream PCS 11 Corporation, VoiceStream Kansas City, Inc., and Powertel/Memphis, Inc.—collectively, d/b/a T-Mobile, New Cingular Wireless PCS, LLC, Eastern Missouri Cellular Limited Partnership, Kansas City SMSA Limited Partnership, Missouri RSA 11/12 Limited Partnership, Missouri RSA 8 Limited Partnership, and Missouri RSA 9131 Limited Partnership—collectively d/b/a Cingular Wireless, and Nextel West Corp. filed written comments.

COMMENT: The Missouri Independent Telephone Company Group (MITG) filed comments generally supporting the Enhanced Record Exchange Rules. The MITG states that the rules establish a billing record and financial responsibility system for intrastate intraLATA traffic, and it supports adoption of the rules. The MITG states the rules will end the practice of the past five (5) years wherein SBC unilaterally determined and announced changes in billing record formats and compensation responsibilities to the rest of the local exchange carriers in Missouri. According to the MITG, the small carriers have experienced actual failures of the current record-creation system, as evidenced by SBC's failure to record or pay for its own "Local Plus" and Outstate Calling Area traffic, as well as other failures, including SBC's failure to record Alltel wireless traffic. The MITG points to failures in providing sufficient information to rate traffic, failure to identify a financially responsible carrier, and a general inability of terminating carriers to reconcile their recordings with the billing records provided to them. According to the MITG, such failures on the part of transiting carriers inhibit terminating carriers' ability to identify which carriers are failing to meet compensation obligations incurred by originating carriers. The MITG offers the rules as the culmination of more than eight (8) years of small local exchange carrier efforts to assure an interexchange carrier/Feature Group D (IXC/FGD) billing relationship after implementation of intraLATA presubscription for long distance telephone service. Despite discontent that its efforts to implement an IXC/FGD billing relationship have not been successful, the MITG supports adoption of the rules.

The MITG cites eight (8) specific items needed for successful intercompany compensation. According to the MITG, the Enhanced Record Exchange Rules comprehensively addresses all (8) eight of

those items. MITG notes that establishment of the rules will necessitate the maintenance and operation of two (2) different types of billing systems and compensation responsibilities—one (1) for the interLATA network and one (1) for the intraLATA network. Nevertheless, states the MITG, adoption of the rules will implement principles and practices that are preferable to the current lack of any enforceable terminating traffic relationship that has existed since the 1999 termination of Missouri's Primary Toll Carrier Plan. The MITG cites numerous deficiencies of an "originating responsibility" and "originating billing records" system, and states that it is time for improvement. While the MITG remains concerned about what it calls the inherent deficiencies of an originating carrier compensation structure, it supports the rules as a fair attempt to regulate such a compensation structure.

The MITG's written comments express a belief that its intraLATA access tariffs should be followed in all instances. MITG states that transiting carriers are essentially interexchange carriers, and that MITG exchange access tariffs should fully apply to the exchange access traffic transited to its member companies by transiting carriers. MITG also states that its tariffs require the elimination of the LEC-to-LEC network upon implementation of Feature Group D (FGD). Thus, according to the MITG, the LEC-to-LEC network should not exist in the first instance. Moreover, states the MITG, "the ERE rule should not have been necessary." The MITG further opines that establishment of a LEC-to-LEC network will lead to the maintenance and operation of two (2) different billing systems and two (2) different compensation responsibilities for terminating traffic. MITG opines that no justification exists to allow transiting carriers to act as interexchange carriers, yet escape the responsibilities of interexchange carriers. MITG complains of inadequate billing information for, among other matters, wireless traffic. However, MITG concedes that a rule prohibiting interstate/interMTA wireless transiting traffic represents an "improvement."

Lastly, the MITG also supports the ability of terminating carriers to re-examine the success the rules may have on addressing the MITG's concerns over the business relationship codified by the rules. The MITG suggests a reasonable time for re-examination would be two (2) years.

COMMENT: Socket Telecom, XO Communications Inc, and Big River Telephone Company (Socket, XO, and Big River) generally support the Enhanced Record Exchange Rules as written. These carriers are particularly supportive of the provisions that permit terminating carriers to bill from Category 11-01-XX records created at the terminating end office. According to Socket, XO, and Big River, the current practice employed by transiting carriers such as SBC, Sprint, and CenturyTel is simply unworkable in today's telecommunications environment—especially when telephone numbers are ported between carriers. Socket, XO and Big River offer examples to demonstrate how the present system leads to the wrong carrier being improperly compensated for call termination. Socket, XO and Big River opine that use of records created at the terminating end office is a critical step in the right direction if Missouri is going to have facility-based competition.

COMMENT: The Telecommunications Department Staff's (Staff's) comments express support for the proposed Enhanced Records Exchange Rules and, except for additions addressing transiting traffic to and from Internet Service Providers, recommends adoption of the rules without change. Staff provided written comments describing the lengthy process it used to comply with the commission's directive to promulgate rules addressing problems inherent to the LEC-to-LEC network. Staff states that while undertaking such efforts it endeavored not to interfere with existing LEC-to-LEC network billing processes that appear to work, offering by way of example the LEC-to-LEC network traffic and record exchange systems utilized between the former Primary Toll Carriers (SBC, CenturyTel, and Sprint). Staff also states that the proposed rules do not interfere with traffic-recording and billing systems utilized on the Interexchange Carrier (IXC) network, as governed by the Federal Communications Commission (FCC). Staff offers its opinion that adoption of the proposed rules will accomplish the commission's stated objectives as announced in the Order Directing Implementation issued by the commission in Case No. TO-99-593, and in the commission's Order Finding Necessity for Rulemaking that was issued in the instant case. While acknowledging that companies have always had and will likely continue to have instances of billing disputes, Staff opines that the proposed rules will minimize the problem of unidentified traffic, while establishing a framework to resolve billing disputes when they do occur. Staff offers its belief that a rule is necessary to provide guidance to the telecommunications industry.

The Staff's written comments also express concern about Voice over Internet Protocol (VoIP) telecommunications traffic transited to terminating carriers via the LEC-to-LEC network. Staff states its concerns are primarily with call termination, and not call origination. Staff opines that interconnection agreements should be required before VoIP telephone companies are permitted to transit calls over the LEC-to-LEC network. In the absence of such agreements, the Staff recommends changes to this rule which would mandate use of the interexchange carrier network for VoIP telephone call termination.

COMMENT: The Small Telephone Company Group (STCG) supports adoption of the proposed Enhanced Record Exchange Rules as a good first step towards resolving the problem of unidentified and uncompensated traffic on the LEC-to-LEC network. The STCG's written comments provide a review of the long history of transiting traffic in Missouri, beginning with the Primary Toll Carrier Plan and concluding with the present situation. The STCG states it experienced numerous problems with the existing LEC-to-LEC network arrangement, and expresses disagreement with the existing business relationship between its member companies and Missouri's three (3) transiting carriers. The STCG extensively documents instances of unidentified and uncompensated traffic occurring on the LEC-to-LEC network in recent years, and expresses great concern that its member companies are forced to accept one hundred percent (100%) of the risk for such traffic.

Along with its support of the Enhanced Record Exchange Rules, the STCG suggests several changes, which, it says, will represent improvement. Among the improvements the STCG recommends a "sunset" provision for Chapter 29. According to the STCG, the efficacy of this chapter should be examined within three (3) years in order to ensure that the proposed Enhanced Record Exchange Rules are actually working. The STCG proposes adding 4 CSR 240-29.170 to accomplish the sunset provision. The STCG opines that addition of a sunset provision will provide for commission review of the effectiveness in eliminating unidentified and uncompensated traffic.

The STCG suggests the proposed rule prohibits interLATA wireline and interMTA wireless traffic from using the LEC-to-LEC network. The STCG states it supports such limitation. According to the STCG, this limit would prevent additional types of traffic from being transited that may be unidentified and unbillable. The STCG expresses concern that the definition of the LEC-to-LEC network may permit SBC to circumvent the rule by sending interLATA calls to STCG member companies for call termination. Other than to suggest clarification be made, the STCG's comments offer no suggestion as to what such clarification might be.

COMMENT: CenturyTel opposes the Enhanced Record Exchange Rules. CenturyTel states that the rules are unnecessary, and that they will create inefficiencies and increase costs. CenturyTel characterizes issues related to the LEC-to-LEC network as compensation issues, and suggests the issues have mostly been resolved. CenturyTel notes that Peace Valley Telephone Company and Alltel are the only two (2) small local exchange carriers subtending its tandem switches, and neither company has expressed concerns regarding CenturyTel's record exchanges occurring thereon.

COMMENT: SBC recommends the commission refrain from adopting the Enhanced Record Exchange Rules at this time. According to

SBC, no showing has been made of any need to adopt such rules. SBC states that no formal complaints have been lodged involving unidentified traffic, and that the complaints that have been filed focused on the rate charged for transited wireless traffic. SBC opines that these issues have mostly been resolved through wireless termination tariffs and traffic termination agreements involving wireless carriers and small telephone companies. SBC points to the billing records it is now creating, and states that such records now capture traffic that previously went unreported. SBC offers that the Enhanced Record Exchange Rules impose unnecessary costs and unwarranted regulatory burdens on the Missouri telecommunications industry. While SBC does not believe a rule is warranted at this time, SBC does note its agreement with those aspects of the rules that establish the principle that the originating carrier is the carrier responsible for compensating all downstream carriers for transiting traffic. According to SBC, this concept is consistent with federal standards.

SBC's written comments oppose this rule to the extent that it seeks to impose restrictions on a carrier's lawful use of its own network. SBC opines the commission has no authority to impermissibly interfere with federal law and the commission's own rulings which, for example, expressly permit SBC to provide interLATA telecommunications services. According to SBC, the rule co-opts management rights of transiting carriers for traffic occurring over their own networks, and unlawfully impairs the financial value of SBC's LEC-to-LEC network. SBC states that the rule results in an unlawful taking in violation of state and federal constitutions.

COMMENT: Sprint filed written comments stating its long-standing and adamant opposition to enactment of the Enhanced Records Exchange Rules. Sprint submits that the proposed rules would create new and additional problems for both the industry and the commission that would outweigh any potential benefits. Sprint states that only five (5) small carriers subtend its tandem offices, and cites figures to compare the customers served by small carriers to those served by large carriers. Sprint adds that none of the carriers to whom Sprint transits traffic have filed any formal commission complaints against Sprint regarding transiting traffic. Sprint opines that unidentified traffic in Missouri is not a material issue, and suggests that no carrier has presented any quantification of benefits to be received from the proposed rules. Sprint challenges carriers supportive of the rule to quantify the amount of unidentified traffic received. Sprint opines that only under such circumstances will it be appropriate to perform an analysis to determine if the unidentified traffic is even compensable. Sprint offers that the complaints received by the commission have been about compensation or the type of traffic being exchanged—not about large quantities of unidentifiable traffic. Sprint urges the commission to not go forward with its efforts to implement the rules.

Sprint's written comments state that this rule is overly broad. Sprint states that not all long distance carriers have direct access to each Sprint end office. Sprint offers its Platte City exchange as an example of tandem switching that does not necessitate direct trunk transport to and from interexchange carriers. Sprint states that the rule prohibits tandem switching of interexchange telecommunications traffic. Sprint opines that this rule is inconsistent with 4 CSR 240-29.050(1), which does acknowledge common LEC-to-LEC network trunking arrangements used to connect terminating tandem offices to subtending end offices. Sprint suggests the last sentence of this rule be entirely stricken. Sprint also voices concern with placing limitations on use of the LEC-to-LEC network by wireless carriers who may wish to transit interstate/interMTA wireless-originated traffic. Sprint states the commission does not have jurisdiction over such wireless carrier activity. Sprint cites to 47 U.S.C. 332(c)(3)(A) as prohibiting state and local governments from the regulation of wireless carrier market entry. Sprint states that 47 U.S.C. 251(c)(2) permits carriers to interconnect. Sprint opines that this section permits it to transit interstate/interMTA traffic.

COMMENT: T-Mobile, Nextel, and Cingular (collectively, Joint Wireless Carriers) state that the Enhanced Record Exchange Rules do not encourage deployment of new technologies, promote competition, inspire innovation, or reduce regulation—all in contravention of congressional intent. To the contrary, Joint Wireless Carriers submit that the rules will inevitably increase consumer cost. Citing, in particular, 47 U.S.C. section 152(b), section 251(a), section 332(c)(3), and section 253(a), as well as sections 386.020(53)(c), 386.030 and 386.250(2), RSMo, Joint Wireless Carriers question the commission's authority to impose rules governing wireless carriers' use of the LEC-to-LEC network. At minimum, state Joint Wireless Carriers, the commission should make clear that the Enhanced Record Exchange Rules do not apply to wireless carriers or to telecommunications traffic sent or received by wireless customers.

Joint Wireless Carriers' written comments cite federal and state law exempting Commercial Mobile Radio Service providers from the commission's jurisdiction. Joint Wireless Carriers state that federal preemptions apply to intrastate as well as interstate traffic. Joint Wireless Carriers object to the aspect of this rule requiring that interstate/interMTA wireless traffic be directed to the interexchange carrier network. Joint Wireless Carriers allege the commission has already determined that it is impossible to comply with the routing rules it proposes. By allegedly imposing a "triple screening function" during call set-up, Joint Wireless Carriers allege the rule would impermissibly require a fundamental change in how its customers' calls are routed. Joint Wireless Carriers state that number portability may occur to wireless carriers or VoIP telephone companies, thus in some cases making the location of the end user indeterminable, even if "triple screening" were implemented.

Joint Wireless Carriers state a presumption that the commission is proposing this rule to facilitate the ability of rural local exchange carriers to identify wireless traffic that should be assessed interstate access charges. Joint Wireless Carriers characterize the LEC-to-LEC network as one that uses Feature Group C (FGC) protocol, and state that it commingles wireless traffic over the FGC trunk group. Joint Wireless Carriers characterize FGC protocol as "antiquated" and accuse rural local exchange carriers of not modernizing their networks in spite of having received over $216 million in subsidies. Joint Wireless Carriers state the problem with rural local exchange carriers is determining whether wireless calls are to be compensated at reciprocal compensation, or at the rates specified in exchange access tariffs. Joint Wireless Carriers state that even with the addition of an Operating Company Number (OCN), rural local exchange carriers are still unable to determine what rate to apply to any given wireless call. Joint Wireless Carriers characterize wireless termination tariffs as "futile" and state that the only way to charge wireless carriers for call termination is by negotiating appropriate compensation factors. Joint Wireless Carriers state that rural local exchange carriers complain of an inability to identify incoming wireless traffic and cannot determine proper rate application. Joint Wireless Carriers state this problem is largely self-inflicted because rural local exchange carriers have chosen to maintain obsolete FGC networks, despite federal subsidies. Joint Wireless Carriers accuse rural local exchange carriers of deliberately not initiating negotiations with wireless carriers. Joint Wireless Carriers state that Missouri rural local exchange carriers advocate changes in the Unified Intercompensation Regime Case that render the rule requirements obsolete.

Joint Wireless Carriers opine that states cannot regulate market entry or rates charged by wireless carriers. Joint Wireless Carriers calculate the rule would apply to only one percent (1%) of its traffic. Joint Wireless carriers object to the fiscal note reporting less than five hundred dollars ($500) in the aggregate for this rule, and characterize such assumptions as defying common sense and commercial realities.

RESPONSE AND EXPLANATION OF CHANGE: The commission will begin its initial response by first acknowledging the general manner in which numerous commentators submitted written comments. While some commentators associated specific comments with specific rules, other commentators, often at length, responded without acknowledging which rule they were referring to. Moreover,

numerous commentators, rather than associating specific comments to specific rules, chose to lump comments into general categories, or list "issues" or other categories of their own choosing. We also recognize that several of the proposed rules are intertwined such that a comment on one rule may apply to other rules as well. Therefore, wherever possible we have used our judgment and attempted to arrange the commentators' responses to those rules most closely aligned with their comments. Because numerous commentators filed general comments addressing the entire gamut of the Enhanced Record Exchange rulemaking, we address here, in this rule establishing the LEC-to-LEC network, several items of key importance that have been brought to our attention.

We first acknowledge the general comments filed by various parties addressing the reported problems associated with traffic traversing the LEC-to-LEC network. We recognize the comments and viewpoints of Missouri's three incumbent transiting carriers—SBC, Sprint, and CenturyTel. SBC, in particular, points to the improvements that have been made to its records creation process while CenturyTel and Sprint generally dismiss past critiques of record exchange and ascribe most issues to a collections problem. At most, according to the transiting carriers, whatever problems that may have previously existed have largely been corrected. Some companies question the extent to which any problems ever existed on the LEC-to-LEC network.

The transiting carriers' comments are contrasted with the extensive documentation of problems experienced by the member companies of the MITG and STCG. The MITG and STCG comment extensively on the traffic-recording and billing problems associated with the LEC-to-LEC network and state that these problems have occurred since elimination of the Primary Toll Carrier Plan. These commentators point to the various docketed cases giving rise to the proposed rules. The MITG correctly points out that many of the issues challenging carriers today are the same issues that were discussed in prior cases. By way of example, the MITG offers Case Numbers TO-84-222; TO-99-254; and TO-99-593. In providing its analysis, these small companies point to past instances of unrecorded traffic generally ranging around twenty-four percent (24%) in July of 2000, to about ten percent (10%) after adjusting for SBC's "Local Plus" traffic. According to testimony at the public hearing on these rules, recent reviews have been conducted for eight (8) companies in an attempt to quantify the extent of any traffic-recording problem that still exists. According to that testimony, unidentified traffic varied from as low as less than one percent (1%) to as high as approximately six percent (6%) of all traffic. Thus, the threshold question we must address is whether sufficient reason continues to exist that would warrant rules to address traffic utilizing the LEC-to-LEC network.

We conclude that minimally invasive local interconnection rules are necessary to address the complex processes and myriad interests of those companies involved with traffic traversing the LEC-to-LEC network. We characterize our rules as minimally invasive because in all instances they simply codify existing practices currently employed by those who are most apprehensive and most opposed to the proposed rules. For example, our modified rules do not seek to regulate the business practices and customer-related activities of nonregulated entities, such as wireless carriers. Our rules are minimally invasive because the record-creation obligations we codify, such as the requirement for tandem providers to create Category 11-01-XX billing records, is simply an acknowledgement of what tandem providers are already doing. Our rules are minimally invasive because, in spite of considerable exhortations to the contrary, we do not seek to change the business relationship that the commission ordered when it eliminated the Primary Toll Carrier Plan. Our rules impose no new record-creation obligations on any carrier; rather, new requirements permitting terminating record-creation is strictly voluntary. Our rules are minimally invasive because trunk segregation occurring under our rules is common industry practice, as evidenced by the voluminous record we have examined and commented upon herein. Our rules do not overextend technical requirements because those requirements contained in the rule, such as the requirement for passage of CPN, do not exceed the technical capabilities commonly employed by all carriers currently using the LEC-to-LEC network. Indeed, and as will be demonstrated, our CPN requirements are entirely consistent with the requirements offered by SBC's replacement Missouri Section 271 Interconnection Agreement (M2A).

We find that a set of local interconnection rules is particularly necessary for transiting traffic because parties receiving this traffic are not involved in the negotiations leading to the traffic delivery. Moreover, and as will be further explained, all terminating carriers must be given more leeway in managing their own networks when receiving traffic from originating carriers. This is particularly true in instances for which the terminating carrier has no traffic termination or interconnection agreement in place. Equally important to rule creation is an environment, as in Missouri's, where the business relationship does not hold the transiting carrier principally or even secondarily liable for traffic delivered to unsuspecting terminating carriers.

We find it particularly necessary to implement local interconnection rules in light of SBC's stated policy that transiting traffic is not subject to Section 251/252 obligations of incumbent carriers. Because we are unaware of the legal positions of CenturyTel and Sprint in this matter, we will confine our comments to SBC by taking official notice of previous testimony of its witnesses and by noting that SBC provides the preponderance of transiting service within our jurisdiction. We note the Direct Testimony of SBC witness Timothy Oyer in Case No. T0-2005-0166. According to Mr. Oyer, SBC is no longer required to submit transiting provisions of its interconnection agreements to the commission because such traffic does not create a Section 251/252 obligation. Moreover, according to Mr. Oyer, a "plain reading" of Section 251(a) makes clear that SBC has no obligation to provide transiting service, and no obligation to subject such service to arbitration under Section 252. According to Mr. Oyer, SBC should be permitted to provide its transiting service pursuant to tariff or individually negotiated agreements not submitted to the commission for approval.

Unlike new entrants, incumbent local exchange carriers cannot avail themselves of federal laws to negotiate interconnection agreements and other matters with other incumbent local exchange carriers. In addressing these matters, the commission will take official notice of its extensive case files as well as the task force reports, committee meetings, written comments and testimony in this case. We find the record before us is one of near constant disagreement among two (2) factions of Missouri incumbent local exchange carriers. One faction is comprised of the three (3) largest Missouri incumbent local exchange carriers, who happen to also be the transiting carriers receiving payment for providing the transiting service. The other faction can best be described as the rest of Missouri's incumbent local exchange carriers, who happen to be small carriers who are not transiting carriers, and who also happen to report great difficulty in receiving compensation for terminating the traffic that is transited to them. We find the matters separating the two (2) factions to be largely unaddressed in federal law. Nor do we find any rules of the FCC which address the disputes that LEC-to-LEC network traffic fosters between these incumbent local exchange carriers. It is for these reasons that we find a modified version of the Enhanced Record Exchange Rules to be of particular importance and necessity. We anticipate that our rules will provide the necessary guidance to reduce instances of traffic-recording and billing problems, and provide a forum for resolution of those problems when they do occur.

While we acknowledge that traffic-recordings have improved since we began this process (a fact acknowledged by the small companies' witness), we disagree with the contention of Sprint, CenturyTel and others who comment that the issues with transiting traffic are primarily limited to that of bill collection. Transiting carriers and nontransiting carriers alike have credited commission-approved wireless

termination tariffs as assuaging concerns with traffic problems occurring on the LEC-to-LEC network. However, we find the future of such tariffs to be seriously in doubt. As was also explained at the public hearing, expected traffic by new facility-based entrants such as the cable telephone companies will place further demands on the traffic-recording capabilities of the LEC-to-LEC network. We find, contrary to assertions of Sprint and CenturyTel, that a major aspect of the difficulties experienced by terminating carriers involves identifying responsible carriers in an environment where no direct business relationship exists. We find that the difficulties experienced by terminating carriers extend far beyond the costly and frustrating experiences of non-payment of invoices. Given the extensive record before us, we will adopt a modified version of the Enhanced Record Exchange Rules as a set of local interconnection rules to address the problems associated with traffic-recording, identification, and collections associated with use of the LEC-to-LEC network. We find that adoption of rules is necessary because the activities of transiting carriers directly affect the financial and operational well-being of terminating carriers who are not presented an opportunity to participate in the negotiation of transiting agreements. Adoption of rules is particularly necessary and timely because the dominant transiting provider, SBC, has ceased offering the commission any opportunity to review the very agreements which obviously affect the interests of third parties who are not a part of the agreements.

We will also use this response section to discuss the commission's authority over the matters pertaining to use of the LEC-to-LEC network. As will be explained further in more detail, we are eliminating those aspects of the proposed rules that restrict interstate interMTA wireless traffic from transiting the LEC-to-LEC network. We are also eliminating those proposed rules requiring wireless termination tariffs. We trust elimination of these items will reduce, if not eliminate, the concerns of wireless carriers. But we cannot accept in total the arguments of those who would have the commission entirely disregard transiting problems on the regulated LEC-to-LEC network simply because nonregulated carriers use the network. The commission is mindful that the LEC-to-LEC network is obviously a continuum of a much larger multi-jurisdictional network, and we will enact our rules in harmony with the rules of other jurisdictions.

We note the comments of Joint Wireless Carriers who cite 386.020(53)(c), 386.030, and 386.250(2), RSMo as precluding our authority over the LEC-to-LEC network when such network is used by wireless carriers not subject to our jurisdiction. Sprint, likewise, questions the commission's authority in this area. Section 386.020(53)(c) excludes wireless service from the definition of telecommunications service. Section 386.030 precludes the commission's authority over interstate commerce unless specifically authorized by the Congress, and section 386.250(2) limits the commission's jurisdiction to telecommunications between one point and another point within Missouri. We also note Joint Wireless Carriers' reference to 47 U.S.C. Section 152(b), Section 251(a), 251(b)(5), Section 332(c)(3) and Section 253(a).

As we have stated, we trust that elimination of certain portions of the draft rules will alleviate the wireless carriers' concerns. However, to the extent the commentators continue to question the commission's authority to establish interconnection requirements of incumbent local service providers, we will first rely upon the commission's general authority over all telecommunications companies found throughout Chapters 386 and 392 and, in particular, section 386.320.1, RSMo 2000. This section sets forth the commission's general supervision of all telephone companies including the manner in which their lines and property are managed, conducted and operated. As stated by counsel for Staff, the Enhanced Record Exchange Rules do not regulate wireless carriers, as the Joint Wireless Carriers and Sprint suppose. Rather, what the rules would regulate is use of the LEC-to-LEC network—not the wireless carriers. We find that section 386.320.1, in particular, places an obligation upon the commission to assure that all calls, including calls generated by nonregulated entities, are adequately recorded, billed, and paid for. We reject Joint Wireless Carriers' apparent contention that nonregulated carriers may use the Missouri LEC-to-LEC network without regard to service quality, billing standards, and, in some instances, with an apparent disregard for adequate compensation. We find this particularly so in the case of transiting traffic because terminating carriers often have little or no knowledge of those carriers placing traffic on the network. Given that terminating carriers are left to bear one hundred percent (100%) of the liability in such situations, we find that minimally invasive rules are necessary to reduce such instances as far as practical.

Joint Wireless Carriers also rely on 47 U.S.C. Section 251 as prohibiting the commission's authority over the transiting traffic generated by wireless carriers. Joint Wireless Carriers specifically cite Sections (a) and (b)(5). We acknowledge the prerogative of wireless carriers to connect to the LEC-to-LEC network with reciprocal compensation agreements based upon the most efficient technological and economic choices. And we acknowledge that wireless carriers may sign, and submit to the commission for approval, agreements to interconnect directly or indirectly with landline carriers. Indeed, we encourage all carriers to sign agreements and submit them to the commission for approval pursuant to federal and state law. However, the record before us is one of far less than complete agreements, signed or otherwise. We are not convinced that one carrier's most technological and efficient interconnection should extend to another carrier's financial loss without an agreement. Moreover, we would note another aspect of Section 251 not cited by Joint Wireless Carriers. Section (d)(3) preserves a state's interconnection regulations. Specifically, this section holds that the FCC may not preclude the enforcement of any regulation, order, or policy of a state commission that establishes access and interconnection obligations of local exchange carriers. We find that the obligation we are imposing on incumbent local exchange carriers is a necessary interconnection obligation on incumbent carriers. Moreover, we can see nothing in our rules that prevents interconnection in the most efficient technological and economic manner, nor do we find anything in our modified rules that is otherwise inconsistent with federal law.

We also note Joint Wireless Carriers' reliance on 47 U.S.C Section 152(b) as giving the FCC authority over intrastate wireless service and Sections 332(c)(3) and 253(a) as preempting state regulation of wireless entry. We note Joint Wireless Carriers' comment that all wireless traffic is interstate, because it is impossible or impractical to determine the end points of wireless calls. Moreover, Joint Wireless Carriers hold that "entry" prohibitions extend to "any" regulation—regardless of whether it prohibits market entry. As we have previously stated, we anticipate that removal of certain proposed rules will lessen concern on the part of wireless carriers. But while we acknowledge federal preemption in the area of wireless services, we do not believe our rules conflict with federal law, because they have nothing to do with the relationship between a wireless carrier and its customers. Rather, our proposed rules have only to do with the terms and conditions that may be required by those who provide services *to a wireless carrier*, and in particular, transiting service. Our rules are not targeted to the practices of wireless carriers; rather, our rules are targeted to the practices of regulated local exchange carriers and the network employed by them—a matter that *is* under the jurisdiction of this commission. In particular, our proposed rules address use of the LEC-to-LEC network, especially that traffic which is transited to terminating carriers who are not a party to agreements made between originating carriers (including but not limited to wireless carriers) and transiting carriers.

The commission agrees with the comment of Joint Wireless Carriers that the addition of an Operating Company Number (OCN) will not determine the jurisdictional rate of wireless telephone calls. We also agree that Calling Party Number (CPN) cannot in all instances be used to determine the proper jurisdiction of wireless calls. We caution all terminating carriers that any attempt to use an OCN or CPN to determine the proper jurisdiction of wireless telephone calls on the LEC-to-LEC network is not permissible under our

local interconnection rules. We recognize this limitation contrasts with processes historically employed on the Interexchange Carrier network in which CPN is used to determine the jurisdiction of wireless calls. Again, we caution that our rules will not permit such practices on the LEC-to-LEC network.

However, this does not mean that billing records should not contain an OCN, because an OCN will, along with other determinates, aid identification of the responsible party, irrespective of the jurisdictional rate to be applied to each wireless telephone call. Similarly, this does not mean that CPN should not be present on each and every telephone call, wireless or otherwise, traversing the LEC-to-LEC network. We disagree with the presumption of Joint Wireless Carriers that the purpose of our rules is to facilitate the ability of rural carriers to identify wireless calls that are to be assessed switched access charges. We also disagree with Joint Wireless Carriers that the FGC network, however defined, is perpetuated by rural carriers when in fact, the evidence before us indicates that it is the small carriers who, for years, have advocated elimination of what Joint Wireless Carriers characterize as the "FGC network." Given the demands placed on the LEC-to-LEC network by wireless carriers, we find instructive the testimony at the public hearing that characterized as "particularly ironic" the Joint Wireless Carriers' notion that the LEC-to-LEC network is "antiquated" and should be done away with.

We will clarify that the purpose of providing CPN on all traffic traversing the LEC-to-LEC network is twofold. First, as described by the STCG, CPN brings full benefit to end users subscribing to Caller Identification service. Secondly, we find that CPN will aid terminating carriers in establishing general auditing provisions for LEC-to-LEC network traffic. For example, CPN can be used to determine the party responsible for placing traffic on the LEC-to-LEC network. Stated differently, the presence of CPN will enable terminating carriers to gather specific information about calls sent for termination even though, due to roaming, the presence of CPN will not always permit determination of the proper jurisdiction of each and every telephone call.

We note the paucity of evidence before us that wireless carriers are unable to transmit caller identification on wireless-originated telephone calls. To the contrary, only Sprint has provided but a single landline example of one exchange incapable of providing CPN on calls traversing the LEC-to-LEC network. The comments filed in this case indicate a simple unwillingness to have local interconnection rules requiring passage of CPN, not an inability to comply with them. We note the extent to which CPN and OCN subject matters were covered in the Task Force meetings and conclude that the evidence before us does not compel acquiescence to the notion that originating carriers are incapable of transmitting CPN, nor are transiting carriers incapable of transmitting it. We note that wireless carriers, in particular, have been required by the FCC to have the capability of transmitting Caller ID as part of Phase One Wireless 9-1-1 procedures. We conclude our rules require nothing more of wireless carriers than has already been required of them by the FCC.

We acknowledge comments of the MITG that codification of the billing relationship inherent in the LEC-to-LEC network will lead to two (2) different billing systems and two (2) different compensation systems. We do not disagree that transiting carriers function as interexchange carriers in many respects, albeit without the obligations of interexchange carriers. We also recognize the likelihood that dual systems have increased costs for small carriers, perhaps substantially. However, decisions to change the traditional LEC-to-LEC network business relationship have been made in past cases and we are hesitant to reverse course without at least giving the new rules a chance to work. We are encouraged that implementation of our local interconnection rules will reduce whatever financial burden may have been caused by past actions of transiting carriers and past instances of unidentified traffic.

We decline to adopt the Staff's request to expand the proposed rules to address transiting traffic traversing to and from the Internet. We find Staff's suggestions to be premature when viewed in light of unsettled developments concerning the Internet. For this reason, we decline to also incorporate the Staff's additional definitions which, according to Staff, were required to support its recommendation for Internet traffic.

We acknowledge the STCG's comments concerning SBC's potential use of the LEC-to-LEC network to terminate interLATA landline traffic without the use of an interexchange carrier's Point of Presence. While we note the STCG's expressed desire for clarification to prohibit such action, we also note that the STCG did not offer suggestions for improvement in this area. Moreover, we find that the STCG's suggestion for 4 CSR 240-29.030(4) does not address its stated concern in this matter. We determine that the STCG's concerns correlate to those of SBC which we address next.

We recognize that SBC is permitted to provide interLATA long distance telephone service pursuant to Section 271 of the Federal Telecommunications Act, and that in many cases it may do so without a separate affiliate. Indeed, we would encourage SBC to avail itself of all rights granted to it under federal law. However, we do not accept that our interconnection rules prohibit SBC's lawful use of its own network nor do we accept that our rules co-opt management rights to employ service offerings to its own customers over SBC's own facilities. While we readily acknowledge SBC's stated concerns in this matter, we find SBC's comments on 4 CSR 240-29.010 to be lacking in specificity as to how the rule brings forth the presumed results. Indeed, SBC does not even set forth with specificity whether it is the interLATA transiting restriction that is the primary area of concern. We will presume that it is, and address our responsive comments accordingly.

We find nothing in our rules that restricts how SBC or any other carrier may provide services over its *own* facilities to its *own* customers. Rather, we find that our rules are intended and in fact do govern instances when one (1) carrier uses *another carrier's* facilities in conjunction with its own facilities to provide service. In particular, our rules address situations where no contract exists between a tandem company and a non-affiliated terminating company. As will be further clarified, we find that our rules do not preclude SBC from providing interLATA service to its customers in, for example, Sacramento, California, and terminating calls to its customers in Kansas City without the use of an interexchange carrier Point of Presence. In such an example, no facilities other than SBC's own facilities are used to process the call. The LEC-to-LEC network is not used because calls do not leave SBC's own network nor are calls transited or otherwise sent to unsuspecting terminating carriers. Our rules do not cover such instances—indeed, no interconnection even takes place—and consequently SBC's unlawful takings argument is unsupportable. For the same reason, we do not believe that our rules "impair the financial value" of SBC's network. It is only when SBC (or another transiting carrier) chooses to send calls to another local exchange carrier that our interconnection rules intercede. In such instances, SBC is no longer merely "using its own network." Rather, SBC (and other transiting carriers) are most certainly using the networks of other terminating carriers, often without the knowledge of those carriers. Moreover, the record before us clearly demonstrates numerous instances occurring over several years whereby terminating carriers suffer financially from traffic (much of it transited) terminating on their networks without proper compensation. This is in contrast to many of SBC's commission-approved interconnection agreements which clearly establish that SBC is financially compensated for transiting traffic on behalf of originating carriers. Under those situations, it would seem more likely that any "takings" are directed more to unsuspecting terminating carriers, rather than SBC. We find that under such circumstances, our rules quite properly set forth the arrangement in which such interconnection takes place and we cannot accept SBC's unlawful takings argument.

We are convinced that SBC's inversion of the takings argument is a result of its misinterpretation of the description of the LEC-to-LEC network as covered in the Task Force meetings, as explained in the

August 18, 2003 revised draft rule that was distributed to all Task Force parties of record, and as established by rule in this section. SBC's interpretation of the definition of the LEC-to-LEC network suffers the same fatal flaw as those of numerous other commentators. Simply stated, SBC and others misinterpret the impacts of our rule because of the common practice of confusing FGC call protocol, which is a particular signaling protocol used only in the originating direction of a telephone call, with a LEC-to-LEC telephone network, which consists of facilities and trunking arrangements used to transport calls between local exchange carriers in both the originating and terminating directions.

We will rely on the testimony referenced in footnote 19 of SBC's comments to illustrate our concerns about many commentators who mischaracterize the LEC-to-LEC network. Footnote 19 references the Direct Testimony of SBC witness Scharfenberg filed on November 30, 2000, in Case No. TO-99-593. We adopt Mr. Scharfenberg's Exhibit 3 and find that it depicts the LEC-to-LEC network as beginning with the inclusion of the originating tandem office and concluding with the inclusion of the terminating tandem office. We find this exhibit (and the accompanying narrative) specifically excludes the "common trunks" connecting the terminating office as a part of the LEC-to-LEC network. Mr. Scharfenberg's diagram simply characterizes the end office connections as "common trunks," in obvious recognition of the fact that they are not exclusive to either the LEC-to-LEC network or the IXC network. We note Mr. Scharfenberg's narrative of Feature Group C (FGC) and Feature Group D (FGD) call protocol, and we direct commentators specifically to this part of his testimony. Mr. Scharfenberg correctly describes FGC and FGD call protocol as occurring on the common trunks and pertaining exclusively to call origination and not call termination. This testimony correctly states that calls in the terminating direction do not use FGC or FGD protocol; rather, such calls are terminated with the use of a simple ten (10)-digit routing scheme without the use of any call protocol. Commentators are cautioned to refrain from characterizing the common trunks, the LEC-to-LEC network, and the IXC network as a "FGC network" or a "FGD network" because FGC and FGD have nothing to do with a network. Rather, FGC and FGD refer to the particular manner in which calls are originated *on a network*. We ask commentators to properly use the terms FGC and FGD and to do so only when referring to a specific type of call origination. Because of the uniqueness of the common trunking arrangement, and because FGC and FGD refer to a specific call protocol used only in the originating direction, we have refrained from characterizing our rule as applying to a "FGC network" and instead have chosen to refer to the LEC-to-LEC network according to the expert testimony of Mr. Scharfenberg. Commentators, such as the STCG, who characterize call termination as a FGC or FGD function are simply incorrect. Moreover, commentators, such as Sprint and CenturyTel, who mistakenly conclude that our rules preclude tandem switched transport because "FGD traffic" cannot be "terminated" on common trunks are equally mistaken for the same reason.

Thus, we conclude that our rule is clear and that it does not hamper SBC's ability to utilize its own network for its own purposes. InterLATA calls may be terminated by SBC (or any carrier) on its own network without the use of an interexchange carrier's Point of Presence. However, absent a commission-approved interconnection agreement or variance from these requirements, SBC is precluded by our rules from using its tandem switching operations to terminate interLATA calls to another carrier without the use of an interexchange carrier's Point of Presence. Utilization of tandem functions in such manner constitutes use of other non-affiliated carriers' property via the LEC-to-LEC network. Without approval of the affected terminating carrier, such action is prohibited. We conclude that preclusion of such action does not co-opt management rights of SBC, does not impermissibly interfere with federal law, does not impermissibly impair the financial value of SBC's network, and does not result in unlawful takings. We conclude that as a general matter, SBC may use its own network for its own purposes, but SBC's own network ends where another carrier's network begins—that is, at a meet-point or meet-point like interconnection facility. Similarly, SBC management rights to use its network for its own purposes must end where a terminating carrier's rights begin. We will not permit SBC to unilaterally use another carrier's property without formal agreement, while simultaneously shielding itself under the guise of management prerogative.

We also reject the apparent notion of some commentators that the jurisdiction of the FCC is exclusive in matters pertaining to calls that begin in one state and end in another. We cite *Southwestern Bell Telephone Co. v. United States et al.,* 45 F.Supp. 403 (W.D. Mo 1942). There, the FCC attempted to exert jurisdiction of interzone calls traversing between Missouri and Kansas. The court ruled that the Federal Communications Commission was without jurisdiction to regulate such interstate activity. Hence, we find that our local interconnection rules that include intraLATA and intraMTA calls do not infringe on interstate matters, even though LATA and MTA boundaries extend slightly into other states.

We will also use our LEC-to-LEC comments section to address and respond to comments requesting expansion of the rules to include a "sunset" provision. The commission fully expects and acknowledges the likelihood that traffic-recording and billing circumstances will change over time. However, we are reluctant to establish an automatic sunset provision to the Enhanced Record Exchange Rules as advocated by the STCG. Certainly any carrier or group of carriers is free at any time to petition the commission to change, add to, or eliminate any of our rules. Thus, we decline to establish a new rule 4 CSR 240-29.170, as suggested by the STCG.

Lastly, we will use the LEC-to-LEC comments section to respond to recent inquiries focusing on the FCC's February 24th Declaratory Ruling and Report and Order in CC Docket No. 01-92 (Order). We find the FCC's Order instructive on a going-forward basis and, as a result, we will eliminate the aspect of our proposed rule that would require incumbent local exchange carriers to file wireless termination tariffs. We also find the Order provides further evidence of the continued dispute surrounding transiting traffic in general, and wireless transiting traffic in particular. We draw upon the FCC's Order as further reason to adopt minimally invasive rules pertaining to interconnection obligations of incumbent local exchange carriers—especially as it pertains to transiting traffic. We note that paragraph 6 of the FCC's Order provides an overview of the practice by which wireless carriers exchange traffic in the absence of interconnection agreements or other compensation arrangements, and accurately describes the compensation problems it causes. We also note that the Order changes Section 20.11 of the existing FCC rules, which heretofore did not attempt to prohibit wireless termination tariffs, and which, consistent with congressional intent, contemplates that competitive carriers will seek negotiation from incumbents, not the reverse. We concur in paragraph 11 of the Order, which correctly describes the 1996 Act's introduction of a mechanism by which CMRS providers may compel local exchange carriers to enter into bilateral interconnection agreements. We also note footnote 62 of the Order, which reviews the assertions of some commentators who characterize wireless providers generally as net payers of reciprocal compensation with a financial interest to maintain a "bill-and-keep" arrangement. We agree Section 252(b)(1) contemplates that incumbent carriers are to *receive* a request for negotiation—not submit requests for negotiation.

We note that in our proceeding, again, wireless carriers have complained that small landline carriers "have deliberately chosen not to initiate negotiations." Yet the small carriers contend that only after implementation of wireless termination tariffs have wireless carriers begun to approach small carriers with a willingness to negotiate. Yet in spite of the prevalence of wireless termination agreements approved by this commission, we note the record before us again demonstrates instances whereby some wireless carriers continue to

transit calls without interconnection agreements, and without payment for services rendered. Given these circumstances, we will await the outcome of the FCC's rulings which appear to contemplate that terminating landline carriers will engage in negotiations with carriers with whom they have no network connection, nor business relationships. In any regard, by eliminating our draft requirement for local exchange carriers to submit wireless termination tariffs, we are confident that our rules do not come into conflict with the FCC's Order.

The commission determines that the origin of wireless-originated calls transiting the LEC-to-LEC network is best addressed in interconnection agreements, and thus will remove the requirement that interstate/interMTA wireless-originated traffic be directed to the IXC network. The commission also determines that interLATA wireline telecommunications traffic may be terminated over the LEC-to-LEC network, provided the terminating carrier has agreed to accept such traffic in a commission-approved interconnection agreement. We will revise our rule accordingly:

4 CSR 240-29.010 The LEC-to-LEC Network

(1) The LEC-to-LEC network is that part of the telecommunications network designed and used by telecommunications companies for the purposes of originating, terminating, and transiting local, intrastate/intraLATA, inter-state/intraLATA, and wireless telecommunications services that originate via the use of feature group C protocol, as defined in 4 CSR 240-29.020(13) of this chapter. InterLATA wireline telecommunications traffic shall not be transmitted over the LEC-to-LEC network, but must originate and terminate with the use of an interexchange carrier point of presence, as defined in 4 CSR 240-29.020(31) of this chapter. Nothing in this section shall preclude a tandem carrier from routing interLATA wireline traffic to a nonaffiliated terminating carrier over the LEC-to-LEC network, provided such terminating carrier has agreed to accept such traffic from the tandem carrier and such acceptance is contained in a commission-approved interconnection agreement.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 29—Enhanced Record Exchange Rules

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.040 and 386.250, RSMo 2000, the commission adopts a rule as follows:

4 CSR 240-29.020 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 3, 2005 (30 MoReg 50–52). Those sections of the proposed rule with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The public comment period ended February 2, 2005, and the commission received written comments from the staff of the commission and from seven (7) other parties. Three (3) of these commenters generally opposed the rules; the other commenters generally supported the rules. A public hearing was held on February 9, 2005, when the commission heard testimony from the staff of the commission and from eight (8) other witnesses representing six (6) other parties, each of whom had also filed written comments. Two (2) of these parties generally opposed the rules; the other parties generally supported the rules.

COMMENT: Socket Telecom, XO Communications, and Big River Telephone Company (Socket, XO, and Big River) suggest adding a definition to this rule. Socket, XO, and Big River submitted written comments contending that other local exchange carriers may misinterpret 4 CSR 240-29.030 as prohibiting calls destined to Internet Service Providers (ISPs) from traversing the LEC-to-LEC network. According to Socket, XO and Big River, the Federal Communications Commission (FCC) has defined such traffic as interstate in nature, but requires local exchange carriers to provide local services to ISPs rather than exchange access services. In order to remedy such potential misinterpretation, Socket, XO, and Big River suggest adding a definition of ISP-bound traffic and a provision to ensure that it is clear the rule contains no prohibition on ISP-bound traffic from traversing the LEC-to-LEC network. For a definition of ISP bound traffic, Socket, XO, and Big River suggest: "ISP-bound traffic-traffic (excluding CMRS traffic) that is routed by local exchange carriers to or from the facilities of a provider of information services, of which ISPs are a subset." Together with a change to 4 CSR 240-29.030, Socket, XO, and Big River state that they would support the proposed rules.

COMMENT: In its written comments, the Telecommunications Department Staff (Staff) also proposes adding two (2) definitions to this rule. The Staff's proposed definition of ISP-bound traffic is similar to that suggested by Socket, XO, and Big River. According to the Staff, the definition of ISP-bound traffic should denote a subset of information access traffic, and should encompass traffic both to and *from* ISPs. The Staff also suggests adding a definition of ISPs. Staff suggests that an ISP be defined as an entity that provides its customers the ability to obtain on-line information through the Internet. Staff notes that its definitions are needed to support Staff's suggested changes to 4 CSR 240-29.010, which Staff believes are necessary to preclude transiting of ISP-bound calls in the absence of interconnection or traffic termination agreements with the terminating carrier. Otherwise, according to the Staff, interstate Voice Over Internet Protocol (VoIP) traffic will be terminated on the LEC-to-LEC network as local calls and without the knowledge of terminating carriers.

RESPONSE: We find the Staff's Internet suggestions to be premature at this time. We affirm that the LEC-to-LEC network may be used to originate calls to the Internet. However, we find the definition suggested by Socket, XO, and Big River to be too expansive. Instead, we will modify our proposed rules to indicate that calls originated from local exchange carriers to Internet service providers may traverse the LEC-to-LEC network. We will modify 4 CSR 240-29.030(3) to address the concerns of Socket, XO, and Big River.

4 CSR 240-29.020(5)

COMMENT: SBC recommends deletion of the last sentence in subsection (5)(A) because differences in the value within bit fields 167-170 and 46-49 of category 11 records have become standardized.

RESPONSE: SBC's comments do not reflect the fact that Carrier Identification Codes (CIC) are used only by interexchange carriers for traffic originated by the use of Feature Group D (FGD) protocol. SBC's comments do not reflect the fact that none of the traffic traversing the LEC-to-LEC network contains a CIC code. SBC is simply incorrect that this definition is inaccurate. The "validity" of populating an Operating Company Name (OCN) in positions 167-170 instead of a CIC in positions 46-49 does not make the sentence invalid. To the contrary, the validity is affirmed. A billing record generated for LEC-to-LEC network traffic will not contain a CIC code because the carriers utilizing the LEC-to-LEC network are not acting in an IXC capacity. Granting SBC's request to change this definition would leave the false impression that CIC codes are to be

expected in the billing records of traffic recorded on the LEC-to-LEC network. Therefore, we will not adopt SBC's suggested change and we find no inaccuracy in the definition.

4 CSR 240-29.020(17)
COMMENT: SBC suggests revising the definition of Local Access and Transport Area (LATA) to reflect that the permissible areas ofBell Operating Companies may have been, and continue to be, modified. SBC states revisions are necessary to reflect that LATA boundaries have been subsequently modified since their inception. Without explanation, SBC states Missouri's LATA boundaries have been modified.
RESPONSE AND EXPLANATION OF CHANGE: SBC provides no explanation of how the Missouri statute could be valid without references to subsequent LATA boundary modifications yet our rule must contain such references. In any regard, we will not attempt to modify Missouri's revised statutes. Instead, we will revise our definition to be entirely consistent with how the term is defined in Missouri law.

4 CSR 240-29.020(20)
COMMENT: SBC states that modification of this definition is necessary to reflect that the Local Exchange Routing Guide (LERG) is only intended to reflect current network configurations and may not reflect actual network configurations.
COMMENT: The Missouri Independent Telephone Company Group (MITG) notes that failure to turn on numbers registered in the LERG is inappropriate, but characterizes such issues as miscellaneous, and suggests such issues are not properly within the purview of this rule.
RESPONSE: SBC suggests the LERG may not reflect current network configurations due to delays, errors and failure to timely update carrier information. Yet SBC provides no explanation of how network configurations could be updated without use of the information contained within the LERG. We agree with SBC that there may be delays etc. However, because network configurations are dependent on the LERG, we find that the delays referenced by SBC are more likely to occur in network configurations rather than in the LERG. In his Direct Testimony in Case No. TO-2005-0166, SBC witness Oyer testified about reliance upon the LERG to identify end offices, relevant tandems, and for proper delivery of traffic. According to Mr. Oyer, "[I]nformation is maintained in the LERG to assist carriers with identifying the proper routing for the purpose of delivering telecommunications traffic to the appropriate local or access tandem." We find witness Oyer's testimony instructive and convincing. Based on his testimony, network configurations appear to be dependent on the LERG, not vice versa. Yet in its comments SBC suggests the LERG may not reflect network configurations. SBC's comments in the instant case provide no explanation of how network configurations come about without use of the information contained within a LERG. It would seem more likely that SBC's suggestions pertain to translations and trunking arrangements, rather than to the LERG. Therefore, we are unable to accept SBC's proposed change.

4 CSR 240-29.020(34)
COMMENT: T-Mobile, Nextel, and Cingular (Joint Wireless Carriers) hold that the commission has no right to include wireless carriers in its rule definitions.

Sprint expresses concern with the commission's authority over wireless carriers, and suggests this section be modified by eliminating references to wireless carriers.
RESPONSE AND EXPLANATION OF CHANGE: We will amend our definition to be entirely consistent with Missouri statutes.

4 CSR 240-29.020(38)
COMMENT: SBC recommends modifying the definition of "traffic aggregator." SBC opines that more differentiation is needed between the role of a traffic aggregator and that of a transit carrier. SBC states that "traffic aggregators" assume financial and operational responsibility for transiting traffic. SBC further states that an aggregation function may occur at a LEC-to-LEC network tandem location in addition to an end office. SBC also proposes to use the definition of traffic aggregator to codify the Missouri business relationship between transiting carriers and terminating carriers. SBC states that its contracts with other carriers reflect such business relationships and, as such, should be stated in the rule section.
RESPONSE: We disagree with SBC's assertion that our rule describes transiting carriers as placing traffic on the network at a tandem office. In fact, our definition says nothing about where a transiting carrier places traffic on the network. Rather, our rule simply acknowledges that a transiting function occurs with the use of a tandem office. This fact cannot be disputed, in spite of SBC's references to Type I wireless origination. Moreover, we find confusing SBC's suggestion that "transiting carriers and carriers providing switching services are not traffic aggregators." To our knowledge, traffic aggregators do have switches and are providing a "switching service." We also decline to define the functionality of aggregators and transiting carriers based upon financial responsibility. We prefer that our rules define aggregators and transiting carriers based on specific functionality rather than financial responsibility. We find that adoption of SBC's suggestions would create confusion and we decline to adopt the suggested changes.

4 CSR 240-29.020(39)
COMMENT: SBC recommends modifying the definition of "transiting carrier." To help differentiate the role of transiting carriers from traffic aggregators, SBC suggests adding the following: "Transiting carriers and carriers providing switching services are not traffic aggregators."
RESPONSE: We decline to make changes to this definition for the reasons stated in our response to 4 CSR 240-29.020(38).

4 CSR 240-29.020(42)
COMMENT: SBC suggests eliminating reference to specific unbundled network elements from this section. SBC opines that it is not appropriate to list specific elements in light of a recent court ruling.
RESPONSE AND EXPLANATION OF CHANGE: SBC's suggestion properly acknowledges unbundling obligations under Section 251 but neglects to acknowledge the duty of state commissions under Section 252 to determine items to be unbundled under Section 251. Thus, we decline to limit elements to those items solely determined by the FCC. Nevertheless, we recognize that the list of unbundled items may change over time and we will modify our definition to denote that such items as loops, ports and transport may or may not be included among the items required to be unbundled.

4 CSR 240-29.020(43)
COMMENT: SBC states that a recent court decision necessitates deletion of the definition of "UNE-P".
RESPONSE AND EXPLANATION OF CHANGE: We agree with SBC that recent court rulings necessitate deletion of the term UNE-P. To the extent UNE-P or "UNE-P like" arrangements continue to exist within the LEC-to-LEC network, we will refer to these arrangements as "shared switch platforms." We will eliminate the definition of "UNE-P."

4 CSR 240-29.020 Definitions

(17) LATA (Local Access and Transport Area) means that term as defined in section 386.020(29), RSMo Supp. 2004.

(A) IntraLATA telecommunications traffic is telecommunications traffic originating and terminating within the same LATA.

(B) InterLATA telecommunications traffic is telecommunications traffic originating and terminating in different LATAs.

(34) Telecommunications Company means those companies as set forth by section 386.020(51), RSMo Supp. 2004.

(42) Unbundled network elements (UNE) are physical and functional elements of an incumbent local exchange carrier's network infrastructure, which are made available to competitors on an unbundled basis. Such elements may include, but are not limited to, local loops, switch ports, and dedicated and common transport facilities.

(43) Wireline communications means all telecommunications traffic other than telecommunications traffic originated pursuant to authority granted by the U.S. Federal Communications Commission's commercial mobile radio services rules and regulations.

(44) A wireline carrier is any carrier providing wireline communications.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 29—Enhanced Record Exchange Rules

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.040 and 386.250, RSMo 2000, the commission adopts a rule as follows:

4 CSR 240-29.030 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 3, 2005 (30 MoReg 52). Those sections of the proposed rule with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The public comment period ended February 2, 2005, and the commission received written comments from the staff of the commission and from seven (7) other parties. Three (3) of these commenters generally opposed the rules; the other commenters generally supported the rules. A public hearing was held on February 9, 2005, when the commission heard testimony from the staff of the commission and from eight (8) other witnesses representing six (6) other parties, each of whom had also filed written comments. Two (2) of these parties generally opposed the rules; the other parties generally supported the rules.

COMMENT: Consistent with its comments in 4 CSR 240-29.010, the Telecommunications Department Staff (Staff) suggested adding two (2) additional sections to this rule in order to clarify that interconnection agreements are necessary before originating wireline carriers are permitted to transit Voice over Internet Protocol (VoIP) traffic that was originated beyond the terminating carrier's local calling area. The Staff also recommended addition of a section requiring telecommunications carriers to program switch translations in observance of the Local Exchange Routing Guide (LERG).
RESPONSE: We decline to adopt the Staff's suggestions to expand the application of our rules to include traffic from the Internet. As we have stated, the Staff's suggestions are premature, given the unsettled nature of the Internet. We also note the "substantial concern" expressed at Hearing by the Small Telephone Company Group (STCG) pertaining to Staff's suggestions for updating the LERG. The STCG witness opined that Staff's suggestion would require intraLATA transport of long distance telephone calls. While we do not agree that Staff's suggestions have anything to do with transport obligations of any carrier, we nevertheless will not incorporate the Staff's recommendation. And while we also note that the Missouri Independent Telephone Company Group (MITG) has perhaps been the most vocal about large carriers who refuse to activate LERG switch recordings, we also note that even the MITG characterizes these actions as "miscellaneous" and suggests they are not properly within the purview of our rules. Thus, we decline to adopt the Staff's suggestions simply because of a lack of industry support even from those who are perhaps most affected.

4 CSR 240-29.030(1)
COMMENT: T-Mobile, Nextel, and Cingular (Joint Wireless Carriers) object that this section unfairly limits the way wireless calls are routed. Joint Wireless Carriers state that the commission should make clear that the rules do not apply to the manner in which wireless carriers send and receive transiting calls to terminating carriers.
RESPONSE: We have deleted wireless carriers from the definition of a telecommunications company as stated in 4 CSR 240-29.020(34). Therefore, we see no reason to change this section.

4 CSR 240-29.030(2)
COMMENT: Joint Wireless Carriers object that the interstate, interMTA restrictions place limitations on how wireless calls are routed. Joint Wireless Carriers offer roaming as an example of how caller identification may not reliably indicate the jurisdictional nature of a wireless call. Using an "end-to-end" analysis as an example, Joint Wireless Carriers opine that small local exchange carriers might "assume" some calls are intrastate when in fact such calls may be interstate. Joint Wireless Carriers mention calls originating in Illinois as an example of the mobility of the calls that wireless carriers route to the Missouri LEC-to-LEC network. Joint Wireless Carriers contend such calls may originate in Illinois "or from any other location in the country." According to Joint Wireless Carriers, wireless users pay the same price for calls irrespective of the distance or location of the number dialed. Joint Wireless Carriers characterize such offerings as "One Rate" offerings. According to Joint Wireless Carriers, it is important for the commission "to understand" that interexchange carriers act as "transit carriers" for mobile-to-land calls. Thus, according to the comments of Joint Wireless Carriers, wireless carriers do not provide any "toll service" to customers.
COMMENT: Sprint questions the commission's authority over wireless carriers, and recommends elimination of this section.
RESPONSE AND EXPLANATION OF CHANGE: The absence of Joint Wireless Carriers from the Industry Task Force meetings is made clear by a reading of its comments to this rule. The commission disagrees with Joint Wireless Carriers' contention that we are implementing Caller ID rules to determine the jurisdiction of roaming wireless calls. We also note Joint Wireless Carriers' references to use of the LEC-to-LEC network for delivery of transiting traffic originated nationwide. We will consider Joint Wireless Carriers' comments as constituting a *prima facie* admission to local interconnection trunk usage instead of interexchange carrier trunk usage for delivery of nationwide interstate interMTA wireless-originated calls. Although this section has nothing to do with roaming or end-to-end analysis, we nevertheless will delete this section and leave the matter of nationwide interstate interMTA transiting traffic as a subject for negotiated agreements between wireless carriers and terminating carriers.

4 CSR 240-29.030(3)
COMMENT: As also reflected in its comments on 4 CSR 240-29.010, the STCG supports limiting interLATA landline calls from using the LEC-to-LEC network. According to the STCG, such limitation will prevent additional types of traffic from being delivered that may be unidentifiable and unbillable. The STCG's comments suggest that SBC may have plans to terminate interLATA calls without the use of an interexchange carrier point of presence. This, according to the STCG, will likely compound the problems with uncompensated and unidentified traffic, such as that demonstrated with SBC's Local Plus.
COMMENT: Consistent with their comments on 4 CSR 240-29.010, Socket Telecom, XO Communications, and Big River Telephone

Company (Socket, XO and Big River) submitted written comments hoping to avert misinterpretation of this section from applying to ISP-bound traffic. Socket, XO, and Big River suggest addition of the following: "Nothing in this section is meant to apply to ISP-bound traffic."

RESPONSE AND EXPLANATION OF CHANGE: We acknowledge the comments of the STCG and agree that this section will limit the likelihood that interLATA landline traffic will be delivered to terminating carriers without their knowledge. We find this section to be particularly useful to terminating carriers given Missouri's business relationship for transiting traffic. We acknowledge the possible difficulty of tracking down and attempting to collect for transiting traffic from Missouri carriers who are providing intraLATA and intraMTA telephone service. We do not wish to compound this problem by permitting Missouri's transiting carriers to expand the LEC-to-LEC network nationwide, or even worldwide. With an originating payment responsibility plan, we find that requiring terminating carriers to locate responsible out-of-state originating carriers would impose hardships that we find unreasonable and are not willing to impose. We do not wish to place additional burdens on terminating carriers by requiring them to track down originating carriers all over North America, or beyond, simply to be paid for terminating transiting traffic.

We acknowledge the stated concerns of Socket, XO, and Big River. We will modify this definition to ensure that it does not apply to calls delivered from local exchange carriers to Internet Service Providers.

4 CSR 240-29.030(4)

COMMENT: In addition to its own end offices, CenturyTel explains that it has two (2) carriers subtending its Missouri tandems—Peace Valley and Alltel—and that neither carrier has expressed concerns over record exchange. CenturyTel states that even though Peace Valley and Alltel have not expressed concern, this section would eliminate tandem-switched transport to all end offices subtending CenturyTel tandem locations, unless CenturyTel installed separate IXC and LEC-to-LEC network trunk groups. CenturyTel complains that such artificial and unreasonable restrictions will create inefficiencies and increase costs.

COMMENT: In conjunction with its comments on 4 CSR 240-29.010, Sprint also opines that this section will serve to prohibit tandem switched transport. Sprint states that, pursuant to this section, interexchange carriers will have to lease direct connections to each end office subtending a Sprint tandem. Sprint points out that, historically, most long distance carriers do not lease direct trunk transport to end offices as that option is cost prohibitive. Sprint suggests this section be eliminated.

COMMENT: The STCG states that the common trunk group is used to originate traffic via Feature Group D (FGD) protocol and terminate traffic via FGD protocol on the LEC-to-LEC network. According to the STCG, the important distinction is that FGD traffic does not terminate as Feature Group C (FGC) traffic. Therefore, suggests the STCG, this section should be revised such that: "No carrier shall terminate traffic on the LEC-to-LEC network as FGC traffic when such traffic was originated by or with the use of feature group A, B, or D protocol trunking arrangements." This change, according to the STCG, takes into account the fact that FGD traffic does terminate over the LEC-to-LEC network, yet preserves the rule's intent to prevent such traffic from terminating as FGC traffic.

RESPONSE: This section precludes the practice whereby calls may be terminated on local interconnection trunks subject to reciprocal compensation when in fact they were originated on meet-point trunks and are subject to access charges. The section seeks to assist local exchange carriers, such as Sprint, CenturyTel, and the STCG member companies, in collecting tariffed charges by limiting potential instances of tariff arbitrage. CenturyTel and Sprint's insistence that this section eliminates tandem-switched transport is simply misplaced. For the reasons expressed in our Response to 4 CSR 240-29.010, Sprint and CenturyTel are simply incorrect in their belief that FGD and FGC are synonymous with, and constitute, a "network." Similarly, the STCG's contention that calls terminate via FGC or FGD signaling protocol is technically flawed and scientifically incorrect. As we have explained previously, FGC and FGD are specific protocols used only to originate traffic and have nothing to do with a "network." CenturyTel and Sprint's definition would attempt to depict common trunks as part of a "network," when in fact they are not exclusive to the LEC-to-LEC network or the IXC network. Hence, there is nothing in our rules prohibiting tandem-switched transport IXC calls from using ten (10)-digit call-screening processes to terminate calls over a common trunk group. We decline to accept Sprint's recommendation to eliminate this section and we reject CenturyTel's contention that this section leads to inefficiencies. The efficiencies inherent in separating trunk groups for LEC-to-LEC traffic and IXC traffic are evident by the plethora of interconnection agreements we have approved which contain separations for the two. We will implement this section without change.

4 CSR 240-29-030(6)

COMMENT: The STCG supports this section's clarification that nothing in this chapter will alter the record-creation or billing processes and systems currently in place for traffic originated by interexchange carriers via the use of feature group A, B, or D protocols.

RESPONSE: We find that it would be unnecessary and inappropriate to interfere with the processes occurring on the federally regulated interexchange carrier network. We will adopt this section without change.

4 CSR 240-29.030(7)

COMMENT: SBC objects to this section which requires interconnection agreements to comport with the rule. Among other objections, SBC states that the commission may only review agreements within ninety (90) days of submission to the commission, or within thirty (30) days for adopted agreements. SBC opines that no further review may occur after these time periods. SBC further states that the commission must make clear that bringing interconnection agreements into compliance with the rule may occur only on a prospective basis. SBC proposes the section be amended with the addition of the following language: "…upon expiration of these agreements…."

COMMENT: CenturyTel likewise states that modification of existing interconnection agreements could only be applied on a prospective basis. CenturyTel notes its disagreement with Staff's fiscal note analysis suggesting that no fiscal impact would be attributed to renegotiation of existing interconnection agreements.

COMMENT: Sprint objects to this section, and recommends it be eliminated. Sprint opines that federal law prohibits state commissions from enacting rules to modify interconnection agreements.

COMMENT: The STCG witness commented at the public hearing that most interconnection agreements contain provisions allowing for a change to the agreement in the event of a change in law or rules which may affect the agreement.

RESPONSE: We first note the paucity of evidence to demonstrate that any of our rules conflict with any existing interconnection agreement. In fact, we can find no comment and nothing in the record to suggest that any of our rules conflict with any existing agreement. Given the record before us, we have no reason to doubt the statement of zero fiscal impact attributed to this section and we thus cannot accept CenturyTel's suggestions to the contrary. We will implement this section without change. In the unlikely event this section or any of our rules require renegotiation of certain portions of existing agreements, carriers may avail themselves of the change-of-law provisions within those agreements.

4 CSR 240-29.030 General Provisions

(2) No originating wireline carrier shall place interLATA traffic on

the LEC-to-LEC network. This section shall not apply to calls delivered from local exchange carriers to Internet Service Providers. Nothing in this section shall preclude a tandem carrier from routing interLATA wireline traffic to a non-affiliated terminating carrier over the LEC-to-LEC network, provided such terminating carrier has agreed to accept such traffic from the tandem carrier and such acceptance is contained in a commission-approved interconnection agreement.

(3) No carrier shall terminate traffic on the LEC-to-LEC network, when such traffic was originated by or with the use of feature group A, B or D protocol trunking arrangements.

(4) No traffic aggregator shall place traffic on the LEC-to-LEC network, except as permitted in this chapter.

(5) Nothing in this chapter shall be construed to alter, or otherwise change, the record creation, record exchange, or billing processes currently in place for traffic carried by interexchange carriers using feature groups A, B, or D protocols.

(6) All carriers with existing interconnection agreements allowing for the exchange of traffic placed on the LEC-to-LEC network shall take appropriate action to ensure compliance with this chapter unless the commission has granted a variance from the requirements of this chapter.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 29—Enhanced Record Exchange Rules

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.040 and 386.250, RSMo 2000, the commission adopts a rule as follows:

4 CSR 240-29.040 Identification of Originating Carrier for Traffic Transmitted over the LEC-to-LEC Network **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 3, 2005 (30 MoReg 53). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The public comment period ended February 2, 2005, and the commission received written comments from the staff of the commission and from seven (7) other parties. Three (3) of these commenters generally opposed the rules; the other commenters generally supported the rules. A public hearing was held on February 9, 2005, when the commission heard testimony from the staff of the commission and from eight (8) other witnesses representing six (6) other parties, each of whom had also filed written comments. Two (2) of these parties generally opposed the rules; the other parties generally supported the rules.

COMMENT: The Telecommunications Department Staff (Staff) filed written comments recommending this rule be implemented without change. Staff indicates it has worked extensively with industry representatives in developing a rule that, in conjunction with 4 CSR 240-29.090, codifies a commission-ordered business relationship between Missouri local exchange carriers. Staff states such business relationship includes a requirement for transiting carriers to create Category 11-01-XX billing records and to make those records available to terminating carriers who seek financial compensation from originating carriers for LEC-to-LEC network call termination. Staff states this policy was implemented upon elimination of Missouri's Primary Toll Carrier plan.

COMMENT: Should the commission determine that 4 CSR 240-29.040 is necessary, Sprint suggests approval be limited to only sections (1), (2) and (5) and (6).

COMMENT: Socket Telecom, XO Communications, and Big River Telephone Company (Socket, XO, and Big River) appear to characterize tandem-created records as a form of originating record-creation and opine that reliance on such records is inaccurate, especially when numbers are ported, and simply does not work in modern environments. Instead, Socket, XO, and Big River advocate use of terminating record-creation as a more satisfactory means of intercompany billing.

COMMENT: SBC states that it is now providing "industry standard" Category 11-01-XX formatted billing records for UNE-P and facility-based CLEC traffic. SBC states that it has discontinued use of the monthly Cellular Transiting Usage Summary Report (CTUSR) for wireless-originated traffic, even though some small carriers previously indicated to the commission such reports were adequate. Without elaboration, SBC also states that it is now using an "industry standard" format for wireless traffic. SBC expresses that it has discontinued its Local Plus intraLATA long distance offering, which was a previous source of vocal opposition due to numerous allegations of billing discrepancies. SBC claims its intercompany compensation billing records capture the traffic that previously went unreported, and that it is working diligently to provide additional information to downstream carriers on traffic that transits SBC's network. SBC proffers that these efforts demonstrate its commitment and follow-through in working cooperatively with small local exchange carriers to obtain records needed to receive appropriate compensation for the traffic terminated. SBC acknowledges that no industry-wide test has yet been performed to determine whether any "material" amounts of unidentified traffic currently exists, with the last such test having been conducted in July, 2000.

SBC states that all carriers have an interest in the creation and distribution of accurate intercompany compensation billing records and, accordingly, opines that a specific rule is not needed in this area. SBC points to an agreement, which it denotes as a set of "Network Principles" recently agreed to by all local exchange carriers in Texas. SBC presents the "Feature Group C Network Principles" (FGC) agreement as Attachment 1 to its comments.

SBC explains that, while it does not believe a rule is necessary at this time, it does agree with the billing relationship established by the rule. According to SBC, longstanding industry practices hold that the originating carrier is responsible for compensating all downstream carriers involved in call completion. SBC cites the federal Unified Carrier Compensation Regime proposed rulemaking as an example of this principle. According to SBC, the carrier who has the relationship with the calling party is also the entity responsible for compensating all downstream carriers. Moreover, states SBC, it is through the relationship with the end user that the originating carrier is able to recover the cost of terminating calls. SBC proffers the Verizon-Virginia arbitration with AT&T, Cox, and WorldCom as an example of where the Wireline Competition Bureau affirmed the standard of "calling-party's-network pays."

SBC also points to the meet-point billing arrangements in the small carriers' own Missouri exchange access tariffs as an example of when access services are billed for, and provided by, more than one (1) local exchange carrier. SBC states that such practices are consistent with national standards promulgated by the Ordering and Billing Forum. SBC characterizes the role of long distance carriers within the interexchange network as comparable to transiting carriers within the LEC-to-LEC network. SBC then explains that both local exchange carriers, in their respective roles, bill their respective access charges attributable to the portion of the jointly provided

exchange access services. SBC goes on to explain that similar multiple bill option processes are outlined in the National Exchange Carrier Association federal access tariff, of which the Missouri small local exchange carriers concur. With regard to its own tariff practices, SBC explains that similar coordinating meet-point billing provisions are contained in the exchange access tariffs of all Missouri transiting carriers. SBC concludes its tariff analysis by stating its belief that, with the creation and exchange of new intercompany billing records, along with the coordinating tariff provisions, it is not necessary for the commission to promulgate a rule. Rather, SBC urges the commission to consider a set of very straightforward and less complicated rules such as those adopted by the Montana Public Service Commission, which SBC appends to its written comments as Attachment 2.

COMMENT: The Missouri Independent Telephone Company Group (MITG) states that the billing records and financial responsibility systems that the rule would establish for the intraLATA LEC-to-LEC network are different from the industry standard Feature Group D (FGD) or interexchange carrier (IXC) systems long in use in the interstate/interLATA jurisdiction. The MITG cites SBC's Local Plus, the Outstate Calling Area plan and Alltel wireless-originated traffic as examples wherein SBC simply neglected to record compensable calls. The MITG expresses a great deal of difficulty in applying an originating responsibility principle to terminating traffic. As explained by the MITG, reliance on an originating records responsibility plan is perfectly acceptable for originating compensation because there is a direct business relationship between the originating local carrier, who receives payment, and the originating interexchange carrier, who pays for the expense of call origination. However, according to the MITG, reliance on such a system for call termination is inappropriate because there often is no business relationship between the terminating carrier, who receives payment, and the originating carrier, who is responsible for payment of terminating expense. According to the MITG, it is simply impractical for any local exchange carrier to attempt to establish and maintain business relationships with every carrier that may originate traffic that happens to terminate in that local exchange carrier's exchanges. Moreover, opines the MITG, SBC is no longer required to transit traffic but, according to SBC's own admission, is doing so voluntarily. According to the MITG, SBC's position is the only attempted justification for adoption of the Enhanced Record Exchange rule.

According to the MITG, transiting carriers such as SBC are no different in the LEC-to-LEC network from interexchange carriers in the IXC network, except that the Missouri commission has determined transiting carriers are not financially responsible for the traffic they transit. As stated by the MITG, both transiting carriers and interexchange carriers perform the very same role in the same manner. As viewed by the MITG, there is no justification to allow SBC to act as an IXC, but to have no responsibility to pay for terminating traffic and, further, there is no justification for SBC to be treated differently than any other IXC. MITG states that there is no dispute that both large and small local exchange carrier tariffs provide that, upon making FGD available, FGC would no longer be provided. The MITG declares that the commission failed to decide that issue then, and has since continued in its failure to decide whether an IXC terminating compensation system should be applied to the traffic on the LEC-to-LEC network.

The MITG cites Oregon Farmer's tariff as an illustrative example of how FGC was to have been discontinued with implementation of FGD. According to the MITG, in at least one (1) instance, Case No. TC-2000-235, the commission did acknowledge SBC as an interexchange carrier by requiring SBC to purchase FGD for the transport of SBC's MaxiMizer 800 service. However, the MITG asserts that the commission has repeatedly neglected to acknowledge elimination of the FGC network in other cases. The MITG cites Case No. TO-97-217, Case No. TO-99-254, and Case No. TO-99-593. In each instance, according to the MITG, the commission failed to address the issue of discontinuing FGC in lieu of FGD. Moreover, the MITG asserts that implementation of OBF Issue 2056 would have given the commission the authority to apply OBF Issue 2056 to the traffic on the LEC-to-LEC network. According to the MITG, OBF Issue 2056 would have given the commission a "state directive" to implement a state-specific plan that could have been applied to LEC-to-LEC network traffic. However, the MITG points out that OBF Issue 2056 was abandoned. Thus, the MITG asserts that the instant rule is being considered after more than eight (8) years of rural local exchange carrier efforts to assure an IXC traffic and business type relationship. Nevertheless, states the MITG, adoption of the business relationship in this rule will end the practice of the past five (5) years, wherein SBC unilaterally determined and announced changes in billing record formats and compensation responsibilities to the rest of the local exchange carriers in Missouri.

COMMENT: The Small Telephone Company Group (STCG) addresses the drawbacks of unidentified traffic inherent in the present situation, and expresses concern that small carriers bear one hundred percent (100%) percent of the risk for unidentified traffic. The STCG maintains that SBC sought an end to the Primary Toll Plan for financial reasons as well as legal and technical reasons. The STCG asserts that SBC's own witness testified that SBC lost approximately $18 million during 1998 by providing intraLATA toll to secondary carriers in Missouri. The STCG also notes that other transiting carriers testified to substantial savings from the elimination of the Primary Toll Carrier plan. The MITG cites Sprint's six hundred thousand dollars ($600,000) annual loss as well. The STCG supports this rule and quotes the following from the Commission's Report and Order in Case No. TO-99-254:

> [T]he Commission will order the provision of standard "Category 11" records. This will provide the SCs [Secondary Carriers] better information about calls terminated to them. Any additional expense this will cause the PTCs is dwarfed by the elimination of the revenue losses they assert they are suffering under the PTC plan.

The STCG states that elimination of the Primary Toll Carrier plan not only relieved SBC's obligation to pay approximately $18 million annually to the small carriers, but the plan elimination also left open a number of questions about the business relationship between transiting carriers and small carriers. Chief among these problems, asserts the STCG, was the question of responsibility for transited traffic and the problem of unidentified, unreported, and uncompensated traffic delivered to the small carriers. As an example, the STCG points to the "Network Test" conducted in July, 2000 as confirming the STCG's concerns about the use of originating records. According to the STCG, of the nine small companies analyzed, less than seventy-six percent (76%) of the terminating records had matches from the originating records. The remaining traffic was unidentified and unbillable, and, on an individual company basis, one company's percentage of matched records was as low as 41.1 percent. The STCG further states that even once significant problems are revealed, it often takes an extraordinary amount of time to correct the problem. Such delays in obtaining corrective action, asserts the STCG, have amounted to extensive financial losses and demonstrate the serious shortcomings with the current originating records system.

The STCG states that concerns regarding "originating records" and "originating carrier" compensation have been well documented over the last five (5) years and small local exchange carriers have suffered financial loss on material amounts of traffic. The STCG asserts that there is no dispute that unidentified and uncompensated traffic continues to be delivered by the transiting carriers. But, according to the STCG, while the transiting carriers have been held financially harmless for their recording mistakes and omissions, the STCG member companies bear one hundred percent (100%) of the risk. Moreover, asserts the STCG, small carriers are required to locate "upstream" carriers and establish billing relationships with those carriers, even though the small carriers have no direct relationship with them. Thus, states the STCG, the transiting carriers have no incentive to address the problem. According to the STCG, although

there are still improvements to be made, it supports the rule as necessary and a first step towards resolution of a problem that is long overdue.

RESPONSE: We first acknowledge agreement with those commentators who maintain that this rule codifies a business relationship for LEC-to-LEC network traffic whereby the originating carrier, not the transiting carrier, is responsible for payment of call termination. But we disagree with those who object to this business relationship without even as much as giving our local interconnection rules an opportunity to work. We also disagree with SBC and others who suggest that local interconnection rules are not necessary because new systems are in place. We simply acknowledge the billing and traffic collections problems revealed in the extensive record before us, and we note the many years this rule has been in development.

We have examined SBC's Texas Network Principles document, submitted as Attachment 1 to its written comments in this case. SBC characterizes this document as a sort of "Network Principles" under which tandem carriers create and share billing records on the traffic traversing each carrier's respective network. According to SBC, the telephone companies in Texas, large and small, agreed among themselves on the principles.

In responding to SBC's comment, we will first note that Missouri carriers are certainly free to agree among themselves to develop a set of network principles, as SBC reports has voluntarily occurred in Texas. In fact, we encourage stakeholders to work cooperatively to reach agreement on technical matters not addressed in our rules. However, we must also recognize that the record before us does not indicate a willingness among Missouri carriers to agree to anything, much less a set of network principles developed independent of commission oversight. We have no doubt that what works in Texas works well for Texas, but we find SBC's document woefully lacking in detail. We note the document's reference to the "Texas IntraState IntraLATA Compensation Plan (TIICP)" and note that Missouri's compensation plan was eliminated in 1999 with the introduction of intraLATA presubscription. It would appear as though the Texas system, whatever it is, is far more extensive than the simple three (3)-page document presented by SBC as Attachment 1 to its comments in this case. We also note the reliance of Texas terminating carriers on the "92 records" system created by transiting carriers and simply note the inadequacy of such system and the fact that Missouri has moved far beyond the "92 system." We note the Texas document requires compilation of additional paperwork and I-LEC questionnaires denoted *"Feature Group C Network Compensation Billing Records Profile."* We find such additional paperwork unsuitable and inefficient for our purposes, and believe a more streamlined process is warranted. We note that SBC's Texas Network Principles is silent on the use of terminating record-creation, yet the Texas Commission has ordered implementation of terminating records creation in the 65-page Arbitration Award in Texas PUC Docket 21982. In summary, we conclude that SBC's Texas Network Principles document, especially when considered in context with other Texas documents, is undoubtedly sufficient for Texas. However, the document in and of itself does not appear comprehensive enough to suit the needs of Missouri. Thus, we decline to adopt any aspect of SBC's Texas document.

We also note SBC's offering of the Montana Public Service Commission's 2001 rule as a more preferable approach to rulemaking. SBC describes the Montana rule as "straightforward" and "less complicated" than our proposed rules. We first note that Montana's rule is derived from legislation passed in Montana known as House Bill 641, Chapter 423, Section 3. As with the Texas document, it appears SBC has submitted only a partial rendition of the actual documents governing the situation being described. In doing so, SBC appears to give the impression that our local interconnection rules are too expansive, and could be more easily accomplished if we would only "do in Missouri what is being done in other states." We thus conclude that SBC's suggestion that the Montana rule is more "streamlined" than our rule appears inaccurate because the Montana rule is accompanied by corresponding legislation and ours is not.

We also note that, pursuant to Montana law, Rule I, paragraph 4 requires transiting carriers to deliver telecommunications traffic by means of *facilities that enable the terminating carriers to identify, measure, and appropriately charge the originating carrier for the termination of such traffic* (emphasis added). We find this concept central to Montana's law and its rules. We note a similar concept first appeared in the draft version of our rules on February 14, 2003. We note this concept later appeared in the May 7, 2003 version and was sent to the parties of record and discussed thoroughly in our Task Force meetings. We also note that, due to concerns of Sprint, the concept was discarded in the August 18, 2003 version of our rules for the supposed financial reasons explained in bullet one of the Staff's August 18th e-mail memorandum to the Task Force participants. We quote the following from 4 CSR 240-29.040(1) of the May 7, 2003, draft version of our rule:

> All [Missouri] telecommunications companies that originate traffic that is transmitted over the LEC-to-LEC network shall use *facilities that enable transiting carriers and terminating carriers to identify, measure, and appropriately charge for that telecommunications traffic.*

(Emphasis added)

We thus find our draft rule of May 7, 2003, to be identical in concept to that which SBC is now advocating. We also note that our records show that at least one (1) carrier, Sprint, attributed a fiscal impact statement of approximately $5 million to this concept. Sprint interpreted this concept as precluding transiting traffic and tandem-switched transport of traffic. Sprint's criticism of this concept caused it to submit unacceptable fiscal impacts because of Sprint PCS's belief that this rule would mandate direct connections to each local exchange carrier end office. We thus conclude that SBC's Montana suggestion, whatever its merits, has already been considered and found wanting by the Missouri Industry Task Force. We decline to renew the concept here and we will disregard as duplicative SBC's suggestion to resume this direction at this late hour.

SBC states that the coordinating tariff provisions and the intercompany billing records now being exchanged preclude the necessity of adopting our proposed rules. SBC maintains that longstanding industry policy requires that originating carriers—the ones with the relationship with the caller—should be responsible for compensating all downstream carriers involved with completing the call. We acknowledge the familiar arrangement whereby the interexchange carrier delivering the call is the same carrier as originated the call. However, we disagree with SBC that such arrangements represent "longstanding industry policy." SBC's analogy is misdirected with regards to interexchange transiting traffic, which we find to be just as prevalent in the interexchange carrier network as it is in the LEC-to-LEC network. In traditional interexchange carrier compensation schemes it is the facility-based transiting carrier (such as AT&T) who is responsible for paying terminating compensation—not necessarily the originating carrier (who may be, for example, resellers or even other facility-based IXCs) who has the billing relationship with the caller. These facts are evidenced by the example given in footnote 31 of Joint Wireless Carriers' written comments in this case. Using wireless-originated calls as an example, Joint Wireless Carriers' describe how originating carriers are not responsible to pay terminating usage fees. Rather, as the example clearly shows, it is the interexchange transiting carrier who is responsible for such payments.

Given the near constant criticism by Missouri's small incumbent carriers to implement a "FGD business relationship" in the LEC-to-LEC network, it would seem axiomatic that traditional transiting carriers are responsible for terminating access charge payments. It is obvious that the small carriers would prefer the LEC-to-LEC transiting carriers (such as SBC) to assume a traditional AT&T transiting relationship. There are many instances where AT&T, acting in

the role of a transiting carrier, is responsible for payment to terminating carriers, even though AT&T may not be the originating carrier and may not have a relationship with the originating caller. As evidenced by its alliances with Williams Communications, Inc., SBC is well versed in the process of relying on another carrier for interexchange transiting service when SBC is the originating carrier. Yet, according to SBC, it wants to duplicate the "longstanding industry policy" of which AT&T and Williams would presumably be the best examples.

We regard the role of LEC-to-LEC network transiting carriers, such as SBC, as similar to IXC transiting carriers in traditional IXC networks, such as AT&T. Such definition is consistent with how we have defined transiting service by function rather than by payment responsibility. Both carriers, in a wholesale capacity, frequently transit calls that neither originate nor terminate on their own network. Both carriers frequently transit calls in instances where they have no relationship with the calling party. In the traditional sense, it is the facility-based transiting carrier—not the originating carrier—who is responsible for paying terminating compensation. We find these circumstances as representative of longstanding industry policy, not the circumstances SBC attributes to this situation in its comments. As even SBC acknowledges, the concept of "calling-party's-network-pays" is a relatively recent phenomenon attributable to the federal government only as recently as December, 2003 in the Verizon-Virginia arbitration order. In Missouri, we first articulated this concept in September 1996. Then, in events pertaining to Case No. TO-96-440, which was our first contested case involving transiting traffic, we directed the applicant, Dial U.S., to obtain traffic termination interconnection agreements with all third parties prior to transiting traffic to them.

In conclusion, we cannot accept SBC's position that meet-point billing access tariffs are sufficient to supplant the necessity for our rules. SBC is simply mixing apples and oranges. As the record before us demonstrates in the first instance, a substantial portion of transiting traffic is wireless traffic not subject to the access payments inherent to the meet-point billing arguments of SBC. As with SBC's Texas Principles document and its Montana rule, we must also reject SBC's contention that its coordinating tariff provisions preclude the necessity of implementing our proposed rules. We will implement this rule without change.

4 CSR 240-29.040(1)

COMMENT: The Staff opines that this section requires all carriers to deliver the originating telephone number of the calling party to all connecting carriers along the LEC-to-LEC network call path. Staff states that it has thoroughly discussed this matter with industry participants and is unaware of any instance where Calling Party Number (CPN) should not accompany the telephone call throughout the call progression.

COMMENT: The STCG supports this section and indicates that implementation will increase all carriers' ability to track and account for traffic delivered over the LEC-to-LEC network. The STCG states that this section will also ensure that customers who subscribe to Caller ID service will receive more calling numbers, thus making Caller ID service more valuable and reducing customer complaints.

COMMENT: T-Mobile, Nextel, and Cingular (Joint Wireless Carriers) complain that this section purports to dictate the kind of signaling information that wireless carriers must provide with the interstate calls their customers originate. According to Joint Wireless Carriers, the "solution" will not fix the "problem"—it will not assist small local exchange carriers in determining whether to bill wireless calls at reciprocal compensation or exchange access rates. Joint Wireless Carriers state that the commission does not have authority over wireless intrastate traffic. Joint Wireless Carriers opine that the Unified Intercarrier Compensation Regime rulemaking will render this rulemaking irrelevant thus stranding investment. Joint Wireless Carriers state, without explanation, that the "unified rate" proposals advocated by Missouri's small local exchange carriers at the federal level would obsolete the modifications and required investments. Joint Wireless Carriers allege that eliminating rate disparity associated with different kinds of traffic, including bill and keep or a uniform rate for call termination, would make the rule irrelevant. Joint Wireless Carriers opine that the commission does not have authority over interstate traffic and Missouri law does not give the commission oversight over wireless communications. Moreover, according to Joint Wireless Carriers, the commission cannot construe the statute in a manner contrary to the plain terms of the statute.

Joint Wireless Carriers assert this rule requires wireless carriers to provide "certain information" along with their calls. Joint Wireless Carriers exert a right to select a transit carrier of choice, and to interconnect directly or indirectly with terminating carriers. Joint Wireless Carriers opine that such rights are based on the wireless carrier's "most efficient technologies and economic choice" and are reserved exclusively with the wireless carrier, and not the incumbent carrier. According to Joint Wireless Carriers, Section 332(c)(3) of the Communications Act bars state government from any authority to regulate entry of wireless carriers. Moreover, according to Joint Wireless Carriers, such preemption exists even if regulation does not actually have the effect of prohibiting entry.

RESPONSE: We find that our rules do not regulate wireless carriers. Rather, our rules represent minimal standards expected of regulated incumbent local exchange carriers for the transport of telecommunications traffic over a locally interconnected network under our jurisdiction. We find that permitting incumbent carriers to transport telecommunications traffic without CPN denies terminating carriers the necessary information required to identify the proper responsible party. Such information is particularly important in an originating responsibility system, such as Missouri's LEC-to-LEC network business relationship. Moreover, failure to transmit Calling Party Identification robs Caller ID consumers of what they are paying for—namely, the calling party's telephone number. We again note the primacy of the FCC's Emergency 9-1-1 standards for wireless carriers, Phase I of which requires transmittal of caller ID for wireless telephone calls. We find that our rules require nothing more than that which has previously been required by the FCC. Lastly, we note that no wireless carrier has provided any evidence that it is incapable of transmitting Caller ID to transiting carriers. We will implement this section without change.

4 CSR 240-29.040(2)

COMMENT: SBC recommends removing the requirement for transiting carriers to deliver originating caller identification to terminating carriers. SBC suggests a sentence be added to reflect that transiting carriers can only deliver caller identification to the extent it receives this information from the originating carrier.

COMMENT: Sprint states that it has one connecting exchange in Missouri where it is unable to deliver originating caller identification to connecting carriers. Sprint expresses concern that the rule makes no exception for this single case of infeasibility. To remedy the matter, Sprint suggests this section be clarified to allow for Sprint's network limitations. Sprint recommends adding the proviso "where technically feasible" to the end of this section.

RESPONSE: We find that delivery of originating caller identification is indispensable for proper billing and recording of call records created at a terminating office. We note this view appears to be substantiated by SBC's Compensation Attachment offering in its replacement Missouri Section 271 Agreement (M2A) as viewed on SBC's web site, as follows:

> 2.1 For all traffic originated on a party's network including, without limitation, Switched Access Traffic and wireless traffic, such party shall provide CPN as defined in 47 C.F.R. Section 64.1600(c) (CPN) in accordance with Section 2.3, below. Each party to this agreement will be responsible for passing on any CPN it receives from a third party for traffic delivered to the other party. In addition, each party agrees that it shall not strip, alter, modify, add, delete, change, or incorrectly assign any

CPN. If either party identifies improper, incorrect, or fraudulent use of local exchange services (including, but not limited to PRI, ISDN and/or Smart Trunks), or identifies stripped, altered, modified, added, deleted, changed, and/or incorrectly assigned CPN, the parties agree to cooperate with one another to investigate and take corrective action.

We find that our caller identification rule is consistent with SBC's own proposed contractual wording as above. We also find that our rule is consistent with the below statements contained in the affidavit of SBC witness McPhee, who in Case No. TO-2005-0166 testified:

P"While I do not discuss issues surrounding IP telephony in this case, the current standard is that CPN information should be passed on all intercarrier traffic."

P"CPN information is critical for determining whether calls are local, intraLATA, or interLATA so that appropriate charges can be applied."

P"This provision protects against the possibility that an unscrupulous C-LEC would fraudulently override call identification or delete CPN so that it can slip interLATA traffic in with local traffic."

We will implement this section without change. The record before us and the record established by the Industry Task Force is clear. There is simply no reason for calls traversing the LEC-to-LEC network to lack CPN. We encourage transiting carriers to require CPN from those with whom they interconnect and provide transiting services. If Sprint or any other carrier is utilizing inferior equipment that does not transmit CPN, those carriers are encouraged to petition the commission for a variance from this rule.

4 CSR 240-29.040(4)

COMMENT: SBC argues that it should not be required to create no-charge billing records for terminating carriers. SBC opines that the commission has no authority to order creation of uncompensated services, and characterizes the practice as confiscatory and contrary to law. SBC says Qwest and other unidentified carriers regularly charge for billing records.

COMMENT: The Staff states that this section leaves in place the current practice of permitting SBC, CenturyTel, and Sprint to use category 92 records for the traffic exchanged among themselves. Staff states this section will also not interfere with the traditional practice whereby transiting carriers create records for their own traffic at an originating end office, rather than at a tandem location.

COMMENT: Sprint states that this section, along with section (3), addresses billing records that are produced days or weeks after the call has been placed. Without explanation, Sprint opines that in some circumstances it is appropriate and acceptable to modify the call record. Sprint, without elaboration, states that carriers should follow industry-standard procedures for the creation of call detail records. Sprint opines, again without explanation or elaboration, that this section "alters industry-standards for records creation [and] exchange."

COMMENT: The STCG states that this section (along with sections (3) and (5)) requires use of industry standard category 11-01-XX billing records and is consistent with prior commission rulings. The STCG supports this section.

COMMENT: The MITG asserts that SBC's Category 11-01-XX billing system does not properly include the calling party number for wireless calls. Instead of providing the caller's number, SBC's record simply puts in an assigned number representing the wireless carrier. Thus, according to the MITG, SBC's improved wireless billing records provide no more information with respect to traffic jurisdiction than did SBC's previous Cellular Transiting Usage Summary Report (CTUSR). The MITG states that the rule will require carriers placing traffic on the network to also place on the network sufficient billing information for the terminating local exchange carrier to properly bill the call to the financially responsible carrier.

COMMENT: Joint Wireless Carriers presume that this section applies to transiting carriers only, and does not require wireless carriers to create billing records for the traffic they create and send to wireline carriers for termination. Joint Wireless Carriers state they would object to any such record-creation obligation. However, Joint Wireless Carriers proclaim this section to be discriminatory on its face. Joint Wireless Carriers opine that record-creation for wireless traffic is improper because no such requirements are similarly imposed on traffic originated by local exchange carriers. Joint Wireless Carriers presume the commission is proposing tandem record-creation to facilitate the ability of rural local exchange carriers to bill the originating carrier for call termination. Joint Wireless Carriers maintain that there is no basis in logic, policy or law for the commission to establish a new category 11-01-XX billing system to facilitate call termination, but then exempt rural local exchange carriers from such a record-creation requirement. According to Joint Wireless Carriers, competitive carriers have a right to bill rural local exchange carriers for call termination as well. Reciprocal compensation, proclaim Joint Wireless Carriers, is embedded in Section 251(b)(5) of the Act. Thus, according to Joint Wireless Carriers, if the commission determines that the public interest would be served by use of Category 11-01-XX billing records, then this requirement should be mandated on transiting carriers for all transiting traffic, including traffic originated on the networks of rural local exchange carriers. Joint Wireless Carriers complain that no explanation is given for such *prima facie* discrimination.

RESPONSE: Because it gave insufficient information, we are unable to comment on Sprint's expressed concern that our rule alters industry standards.

Joint Wireless Carriers exhibit a general lack of knowledge about the LEC-to-LEC network. The record creation obligations codified by our rules do not represent any new record creation obligations. Rather, the obligations were implemented by Missouri's transiting carriers pursuant to our Report and Order in Case No. TO-99-254. Joint Wireless Carriers do not establish any instance whereby rural carriers transmit compensable calls to wireless carriers, yet Joint Wireless Carriers inexplicably characterize this rule as discriminatory because rural carriers are not required to create billing records for calls they do not originate or transit. We determine Joint Wireless Carriers' comments on this section to be frivolous and unsubstantiated.

SBC complains that this rule establishes a no-charge records creation provision, a matter to which it objects and characterizes as confiscatory and unlawful. SBC references Qwest, another Regional Bell Operating Company (R-BOC), as charging for records, and seems to imply that SBC should also be permitted to charge for records. Yet SBC provides no comparative analysis which would permit the commission to draw any conclusions. SBC does not even indicate whether Qwest is a price cap, rate-of-return, or free market price-deregulated carrier. In any regard, we disagree with SBC's characterization of our rule as establishing a no-charge bill creation provision. The record before us indicates that the commission established this proviso in its ordered paragraph 3 of its Report and Order in Case No. TO-99-254, et al. As we also stated in that Report and Order, any additional expense this will cause [SBC, Sprint, and CenturyTel] is dwarfed by the elimination of the asserted revenue losses occurring under the PTC plan.

We acknowledge the MITG claim that SBC strips off the CPN of wireless-originated calls when it creates Category 11-01-XX billing records. We acknowledge such practices render the Category 11 records as non-industry standard. We agree that such practice leaves terminating carriers with little or no more information than was previously contained in SBC's Cellular Transiting Usage Summary Report (CTUSR) summary records. We are unconvinced by the testimony at the public hearing of SBC witness Murphy, who states that it is fitting for SBC to engage in the practice of stripping CPN when it creates Category 11-01-XX billing records for terminating carriers such as the MITG member companies. First, we note Mr. Murphy was referring to creation of Automatic Message Accounting (AMA) records (i.e., "machine records"), not Category 11-01-XX billing records. We note our rules address Category 11-01-XX records and not the AMA switch records Mr. Murphy referred to in his sworn

testimony. We acknowledge that part of the data contained within Category 11 billing records is dependent on source information derived from AMA records. However, we find nothing in the record before us to indicate that CPN is not a part of AMA records. Moreover, we find that Mr. Murphy's testimony presents no evidence that Telcordia Technologies documents permit stripping of CPN when creating Category 11-01-XX billing records. We conclude that the Telcordia Technologies document referenced by Mr. Murphy simply does not address the situation complained of by the MITG.

Mr. Murphy also indicates that industry records for wireless traffic are different from industry records for interexchange carriers because interexchange callers make calls from home or at work. We reject the notion that all interexchange callers are stationary. We first point to footnote 31 of Joint Wireless Carriers' comments to evidence the mobility of some interexchange carrier traffic. We will also take notice of our official records—in this instance, the record developed in Case No. TT-2004-0542 and, in particular, Issue 1.a of that case. We note for the record that on September 27, 2004 SBC withdrew its access revision tariff filing in that case. As SBC is well aware, the use of CPN to determine call jurisdiction is just as controversial for interexchange traffic as it is for wireless traffic for the simple reason that a substantial amount of interexchange traffic is originated from wireless telephones. Thus, we cannot accept Mr. Murphy's pronouncement that interexchange callers are "stationary" and, with the possible exception of an Operating Company Number, we cannot accept the notion that Category 11-01-XX billing records should be different for LEC-to-LEC network traffic than for IXC traffic. The record before us indicates that both networks contain some degree of wireless roaming traffic. Given that AT&T, for example, does not have its own wireless end users, it would seem that in fact all of AT&T's wireless-originated interexchange carrier traffic is roaming traffic. Yet, SBC witness Murphy characterizes interexchange traffic as originating from "stationary" users.

We find that SBC has shown no credible evidence that the Category 11-01-XX billing records it creates for wireless-originated calls traversing the LEC-to-LEC network should be different from the Category 11-01-XX billing records it creates for wireline *and wireless*-originated calls traversing the interexchange carrier network. We also caution terminating carriers that, as used for wireless-originated LEC-to-LEC billing records, the CPN is to be used as far as practical only to determine the responsible party and that, due to possible instances of roaming, CPN cannot be used in all instances to determine call jurisdiction of wireless-originated calls. We urge all carriers to work together in formulating industry solutions that address the ability to use the SS7 Jurisdiction Information Parameter (JIP) or similar indicators to determine proper jurisdiction of traffic traversing the LEC-to-LEC network. We note, in particular, the Ordering and Billing Forum Issue 0208 and events occurring in November 2004 as a possible starting place for Missouri carriers to seek resolution of potential misjurisdictionalized wireless roaming traffic.

We thus determine that transiting carriers shall include the CPN as part of the Category 11-01-XX records created for wireless-originated traffic occurring over the LEC-to-LEC network. If any carrier determines that it cannot or should not include the originating CPN of wireless callers in the Category 11-01-XX billing record, it is free to petition the commission to be excluded from that aspect of our rule. Based on the comments and the record before us, we see no reason to exclude wireless CPN from the billing records generated by transiting carriers. We order implementation of this section without change.

4 CSR 240-29.040(6)

COMMENT: The Staff opines that this section would prohibit a practice whereby unscrupulous carriers may engage in the practice of stripping the correct telephone number and inserting a jurisdictionally improper telephone number into the call path or billing records.

COMMENT: SBC recommends that this section be clarified to acknowledge that in some call forwarding situations, the caller identification of the party forwarding the call is the number that is provided to the transiting and terminating carriers.

COMMENT: If the commission ultimately finalizes the ERE rule, Sprint expresses support for this section. However, Sprint recommends adoption of only section (1), (2), and (5). Sprint recommends deleting sections (3) and (4).

RESPONSE: Because Sprint provided insufficient explanation, we are unable to accept its suggestion to apply this section in a limited manner. Similarly, SBC suggests a change be made but offers no suggestion as to what form the change should take. We find nothing in this section that infringes the technical workings of multiple callforwarding scenarios. It is to be expected that each leg of the call is reoriginated and that a new CPN may be derived on each leg of the call. We will not attempt to use the rulemaking process to address each and every possible technical scenario that may develop in the network. If the parties to this case find it necessary, they are free to work together, with or without enlisting assistance from the Staff, to develop a set of more detailed network principles to guide implementation of our Enhanced Record Exchange Rules. We will implement this section without change.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 29—Enhanced Record Exchange Rules

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.040 and 386.250, RSMo 2000, the commission adopts a rule as follows:

4 CSR 240-29.050 Option to Establish Separate Trunk Groups for LEC-to-LEC Telecommunications Traffic **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 3, 2005 (30 MoReg 53–57). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The public comment period ended February 2, 2005, and the commission received written comments from the staff of the commission and from seven (7) other parties. Three (3) of these commenters generally opposed the rules; the other commenters generally supported the rules. A public hearing was held on February 9, 2005, when the commission heard testimony from the staff of the commission and from eight (8) other witnesses representing six (6) other parties, each of whom had also filed written comments. Two (2) of these parties generally opposed the rules; the other parties generally supported the rules.

4 CSR 240-29.050(1)

COMMENT: The Missouri Independent Telephone Company Group (MITG) states that an option for its member companies to have separate trunk groups for IXC and LEC-to-LEC network traffic is an improvement. According to the MITG, separate trunk groups are needed because there is a separate and distinct billing and compensation system for IXC and LEC-to-LEC network traffic. According to the MITG, in order to distinguish traffic-recording responsibilities, separate trunk groups are needed.

COMMENT: The Small Telephone Company Group (STCG) supports this section and states that this rule is particularly appropriate in a competitive environment.

COMMENT: The Telecommunications Department Staff (Staff) states this section should be implemented without change. Staff asserts that separate trunk groups for IXC and LEC-to-LEC network traffic are standard industry practice among incumbent local exchange carriers such as SBC and Sprint. Staff opines that the commission has approved many such agreements. Staff explains that under the Telecommunications Act of 1996, new competitive companies are permitted to petition incumbent local exchange carriers for separate trunk groups but that small local exchange carriers, such as the small Missouri companies, may not avail themselves of such law. Consequently, it is up to the commission to determine if separate trunk groups will be made optional for local exchange carriers. Staff opines that separate trunk groups are just as important to small carriers as to larger carriers such as SBC and Sprint. The Staff asserts that separate trunk groups help to assure proper compensation and that using separate trunk groups for jurisdictionally distinct traffic is common practice. Staff opines that by opposing separate trunk groups for incumbent carriers, SBC, Sprint, and CenturyTel are engaged in disparate treatment of small local exchange carriers.

COMMENT: Sprint states that this section clearly contemplates that traffic from interexchange carriers will be combined with traffic from wireless carriers and local exchange carriers and, as such, allows separate LEC-to-LEC network and IXC trunk groups. According to Sprint, this section is therefore inconsistent with 4 CSR 240-29.010 and 4 CSR 240-29.030(4).

Sprint suggests this section is inconsistent with Sprint's PSC Mo. No. 26 tariff which states: "different types of FGC or other switching arrangements may be combined on a single trunk group at the option of the Telephone Company."

COMMENT: T-Mobile, Nextel, and Cingular (Joint Wireless Carriers) characterize separate trunk groups as needless. Joint Wireless Carriers presume the commission is proposing this section to facilitate the ability of rural local exchange carriers to identify the wireless traffic that should be assessed interstate access charges. Joint Wireless Carriers state that this is not possible and that the only way to charge wireless carriers for call termination is to negotiate an appropriate interMTA and interstate factor.

Joint Wireless Carriers state that separate trunk groups would use antiquated Feature Group C (FGC) interface. Joint Wireless Carriers opine that costs for installing separate trunk groups might be passed on to wireless carriers in the form of higher transit costs. Joint Wireless Carriers state that these costs would be unnecessary if the Federal Communications Commission (FCC) adopts bill-and-keep for the exchange of traffic. Joint Wireless Carriers assert that separate trunk groups contravene the principle of cost-causation and distort competition as a result. According to Joint Wireless Carriers, the FCC mandates that costs be attributed on a cost-causative basis, as stated in the Verizon InterLATA Order. Joint Wireless Carriers opine that the rules are entirely imposed by the rural local exchange carriers. According to Joint Wireless Carriers, no explanation is given as to why transit carriers are to share in such costs. Joint Wireless Carriers would have terminating carriers subsume the entire cost of installing meet-point like trunks. Joint Wireless Carriers state, parenthetically, that rural local exchange carriers should not be allowed to recover their costs for installing separate trunk groups.

COMMENT: SBC opines that the commission lacks statutory authority to require tandem carriers to make network changes through a rulemaking. SBC cites to section 392.250, RSMo as requiring an adjudicatory hearing prior to the commission ordering network changes. SBC states this section improperly strays into the realm of management prerogatives, and infringes on its right to use and enjoyment of its property. SBC points to its PSC Mo. No. 36 access tariff as permitting routes and facilities as only SBC may elect. SBC states that in this rulemaking the commission has no evidence before it of any company failure to perform legal duties which have harmed the public. SBC characterizes as "generalized dissatisfaction" and "anecdotal" the claims of unidentified traffic, and states that such is not sufficient evidence under the statutory scheme.

SBC states that in previous cases before the commission, SBC and other carriers have opposed use of separate trunk groups to handle different types of traffic. SBC asserts that engineers have testified that separate trunk groups are "extremely inefficient" and costly to implement. As an example, SBC offers the testimony of its witness Scharfenberg in Case No. TO-99-593.

SBC also objects to Staff's reduction of the fiscal impact SBC reported for this section of the rule, and characterizes Staff's actions as improper. SBC states it reported an impact of four hundred forty thousand dollars ($440,000) which Staff reduced to two hundred nineteen thousand dollars ($219,000). SBC questions Staff's statement that Sprint and Spectra are not expected to implement separate trunk groups. According to SBC, such assumption conflicts with the express language of this section. SBC objects that the rule fails to provide any cost recovery mechanism for tandem providers who are impacted by the section. Lastly, SBC recommends placing the cost of implementing this section on the cost-causing requesting carrier.

RESPONSE: We reject Sprint's contention that our rule interferes with its access tariff. We find that Sprint may continue to commingle what it calls "different types of FGC or other switching arrangements" on a single trunk group. Our rules do not interfere with how Sprint handles its own traffic. However, other carriers have access tariffs too. In fact, many of the carriers with whom Sprint interconnects would prefer to apply those aspects of access tariffs that they interpret as eliminating FGC upon implementation of FGD. We note the following from Sheet 185 of Sprint's own P.S.C. Mo. No. 26 access tariff:

> "FGC switching is provided to the customer (i.e., providers of MTS and WATS) at an end office switch unless Feature Group D end office switching is provided in the same office. When FGD is available, FGC will be discontinued for Interexchange Carriers."

We will not permit Sprint to interpret its access tariff in such a way that imposes its traffic intermingling scheme on unwilling participants who have no market-based solution other than to use Sprint's tandem connections. We also disagree with Sprint's comment that this section contemplates intermingling of local and interexchange carrier traffic. To the contrary, this section contemplates separating the two (2) traffic types in a manner consistent with how Sprint has voluntarily agreed to separate its traffic when interconnecting with competitive local exchange carriers.

We reject Joint Wireless Carriers' notion that separate trunk groups are useless. We are not imposing separate trunk groups to facilitate the ability of rural carriers to identify access traffic. We are empowering incumbent local exchange carriers with the tools needed to implement separate trunk groups because there are two (2) separate networks in use, which employ two (2) different traffic-recording mechanisms each with its own unique business relationship, and because separate trunk groups represent the standard employed in today's modern network environment. This simple fact is illustrated by wireless carriers' own use of network trunking arrangements. As demonstrated by Sprint PCS in technical meetings in this case, wireless carriers utilize three general trunk group types: Local, IXC, and Intermachine. We note these three basic trunk group types are already in place to enable the "triple screening" process that Joint Wireless Carriers claim not to utilize. The concept of using specific trunk groups for specific purposes is no different for landline carriers than it is for wireless carriers. We must reject Joint Wireless Carriers' contention that their networks need separate trunk groups but landline carriers' networks do not.

We cannot accept SBC's complaint that Staff wrongly reduced its fiscal impact projection for separate trunk groups. We first note Staff's disallowance of costs that SBC initially attributed to separate trunk groups between SBC and its retail customers, competitive local

exchange carriers, and wireless carriers. We find that Staff was correct to disallow reported costs for SBC's retail customers because our rules have nothing to do with the business trunks SBC provides to private entities. We also find that Staff was correct to disallow costs SBC attributed to competitive local exchange carriers and wireless carriers because these carriers negotiate trunks pursuant to interconnection agreements and our rules do not infringe upon such enterprise.

We conclude that Staff properly disallowed costs that SBC attributed to separate trunk groups between SBC and the other transiting carriers (Sprint and Century Tel). Given the unambiguous opposition of Sprint and CenturyTel to the establishment of separate trunk groups, it is clear that Sprint and CenturyTel do not intend to implement separate trunk groups. Such is further evidenced by special provisions in our rules that permit these carriers and SBC to continue with the Category 92 records creation process, thus negating the possibility that the former Primary Toll Carriers may engage in terminating record-creation for which the separate trunk groups are necessary. We also take official notice of the Task Force meetings and comments in which Sprint and CenturyTel spoke against separate trunk groups. Given these circumstances, we find that Staff was correct to exclude costs for establishing separate trunk groups from SBC to Sprint and CenturyTel. As the Staff instructed the Task Force participants, we again remind SBC that when calculating fiscal note costs, one should calculate what it reasonably expects will occur—not what "could" or "might" occur. We find reasonable the Staff's exclusion of Sprint and CenturyTel from the financial calculations. Lastly, we note SBC's per-trunk cost estimate of two hundred ninety-nine dollars ($299) contrasts sharply with Sprint's per-trunk cost estimate of thirty-nine dollars and fifty-eight cents ($39.58) and CenturyTel's estimate of no fiscal impact. Given the inexplicable disparity, we find Staff's calculations with regard to SBC are more than reasonable. We also reject the contention that terminating carriers are solely responsible for the cost of implementing separate trunk groups. As is customary, we direct each involved carrier to be responsible for its individual cost of implementing the trunk groups.

As to SBC's trunk efficiency arguments, we find an extensive record before us that belies SBC's comments and insistence that separate trunk groups are "extremely inefficient." First, we take official notice of SBC's commission-approved interconnection agreements (and similar agreements of CenturyTel and Sprint) in which SBC has voluntarily negotiated one trunk group for local/intraLATA traffic, and a separate trunk group for IXC network traffic. SBC's voluntary actions in this regard appear to contradict its comments in this case. And while we acknowledge SBC's comments that witness Scharfenberg has testified in Case No. TO-99-593 that separate trunk groups are inefficient, we will also acknowledge SBC witness Timothy Oyer's direct testimony in Case No. TO-2005-0166, as follows:

"Software limitations prohibit both companies from being able to properly identify the traffic they are receiving over combined trunk groups. SBC Missouri makes terminating billing records on incoming trunk groups. All traffic that is sent over a single trunk group will generate the same type of billing record. This is where the opportunity for fraud exists. Level 3 must tell SBC Missouri what percentage of these calls should be billed at a reciprocal compensation rate as opposed to an access rate. Without the ability to identify the traffic, the parties are left no choice but to accept the word of the other as to the true jurisdictional nature of the traffic. Accurate and proper compensation is best accomplished through separate trunk groups. Separate trunk groups allow for traffic to be accurately recorded and then properly billed."

"Level 3's proposal seeking to combine local/intraLATA toll traffic with interexchange access traffic on the same trunk group should be rejected because it would create the potential for blocking as well as significant billing problems without any discernible upside."

"To ensure that Level 3 and SBC Missouri are properly compensated for local, intraLATA and interLATA exchange access, these different traffic types must be routed on separate trunk groups."

"[SBC] Missouri's proposal that jurisdictionally distinct traffic be carried on separate trunk groups is consistent with what the parties' have been doing under their current interconnection agreement in this and other states in which SBC operates as an ILEC."

"Local interconnection trunk groups must be provisioned to support the appropriate traffic. This assures proper routing per the LERG and also allows for proper tracking for compensation."

"Specifically, under its proposed language, Level 3 could combine local/intraLATA toll traffic with interLATA IXC carried traffic on local interconnection trunk groups. SBC Missouri opposes Level 3's proposed language."

"In other state arbitrations, Level 3 has identified several carriers that Level 3 uses for [call delivery], one (1) of which is currently being sued by SBC for access charge avoidance by delivering access calls over local trunk groups."

"…[C]ombining traffic [on a single trunk group] as suggested by Level 3 could potentially lead to blocked calls due to improper routing of calls."

"…[C]ombining jurisdictionally distinct traffic on the same trunk group would create tracking and billing problems."

In summary, we find that SBC's testimony in Case No-TO-2005-0166 negates its position in this case. In one case SBC characterizes separate trunk groups as "highly inefficient," yet in another case it characterizes separate trunk groups as necessary for accurate recording and proper billing. We note that one SBC witness characterizes separate trunk groups as "[too] costly to implement," yet another witness characterizes common trunk groups as presenting "the opportunity for fraud." We conclude that SBC's commentary record on separate trunk groups appears to change with each case presented to us.

Because we find excessive contradiction in SBC's trunking statements, we will examine SBC's market-based local interconnection conduct as the best possible solution for our local interconnection rules. An examination of the interconnection agreements SBC has filed with the commission reveals that such agreements contain provisions for separate trunk groups. We note SBC's market-based behavior in this regard and apply that concept to those instances in Missouri when we have to implement rules because incumbent carriers are not free to compel negotiation from one to the other. We will implement our rules consistent with the manner most closely resembling the market-based solutions as reflected in the interconnection agreements of SBC, Sprint, and CenturyTel. We see no reason to deny the benefits of these modern network technologies to Missouri's incumbent carriers who cannot avail themselves of the same interconnection rights guaranteed under federal law to competitive carriers. As to SBC's remaining arguments, we find that our responses would be duplicative of previous responses and we will not repeat them here. We will order implementation of this section without change.

4 CSR 240-29.050(2)

COMMENT: Sprint recommends this section be eliminated. According to Sprint, this section seeks to change the business relationship between tandem carriers and end office carriers. Sprint opines that the carriers supporting the rule are, yet again, trying to persuade the commission to change the business relationship. Sprint states that the proposed rule contains provisions that accomplish just that.

COMMENT: CenturyTel is opposed to those aspects of our rules that permit establishment of separate trunk groups. CenturyTel states that inclusion of this section constitutes a de facto mandate to change the business relationship between transiting and terminating carriers. CenturyTel cites to two (2) previous occasions wherein the commission has refused to do so.

RESPONSE: We see nothing in this section that would change the current business relationship. This section simply provides an option for tandem carriers to assume financial responsibility in the event they do not wish to honor the request of terminating carriers to install separate trunk groups.

We note that CenturyTel and Spectra's own interconnection agreements mandate separate trunk groups for competitive local exchange carriers as demonstrated by the following:

"Spectra requires separate trunk groups from MTI to originate and terminate interLATA calls and to provide Switched Access Service to IXCs." (Paragraph 4.3.3, Interconnection Agreement between Spectra and Missouri Telecom, Inc.)

"Neither party shall route switched access service traffic over local interconnection trunks, or local traffic over switched access service trunks." (Paragraph 4.3.3.3, Interconnection Agreement between CenturyTel and Missouri Telecom, Inc.)

We find that separate trunk groups do not interfere with the business relationship of CenturyTel and competitive local exchange carriers. Nor do we see any reason that separate trunk groups will interfere with the business relationship between CenturyTel and incumbent local exchange carriers. We will implement this section without change.

4 CSR 240-29.050(4)

COMMENT: Sprint states, without explanation, that after traffic is separated between that which traverses an interexchange carrier point of presence and that which does not, "segregated traffic still rides the LEC-to-LEC network albeit on separate trunks." Sprint seeks clarification on what tandem providers are supposed to do with segregated traffic after it is segregated.

COMMENT: Joint Wireless Carriers state, inexplicably, that this section purports to dictate how wireless carriers must route their interstate interMTA traffic.

RESPONSE: We will clarify for Sprint that it is supposed to treat segregated traffic destined for incumbent carriers the same as it treats segregated traffic destined for the competitors with whom it has voluntarily agreed to segregate traffic. We instruct Sprint to take notice of Section 37 of its own Master Interconnection Agreement in Case No. TK-2005-0278. Section 37, titled, *Local Interconnection Trunk Arrangements*, indicates that Sprint will make available to competitors two (2)-way trunks for exchange of combined Local Traffic, and non-equal access intraLATA toll traffic. Moreover, Sprint will make available to competitors *separate* two (2)-way trunks for the exchange of equal-access interLATA or IntraLATA interexchange traffic. If, after examining its own interconnection agreements, Sprint is still unsure of how to treat segregated traffic, we instruct Sprint to examine its own trunking arrangements in its Lebanon, Ferrelview and Kearney end offices, which are connected to SBC tandems. We are confident that Sprint will find these trunking arrangements instructive because they utilize separate trunk groups to accommodate data, MCA, and intraLATA calls. If, after examining its own agreements and network configurations, Sprint is still uncertain on what it is supposed to do with segregated traffic, it may contact the Staff for further assistance. We order implementation of this section without change.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 29—Enhanced Record Exchange Rules

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.040 and 386.250, RSMo 2000, the commission adopts a rule as follows:

4 CSR 240-29.060 Special Privacy Provisions for End Users Who Block Their Originating Telephone Number **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 3, 2005 (30 MoReg 58). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The public comment period ended February 2, 2005, and the commission received written comments from the staff of the commission and from seven (7) other parties. Three (3) of these commenters generally opposed the rules; the other commenters generally supported the rules. A public hearing was held on February 9, 2005, when the commission heard testimony from the staff of the commission and from eight (8) other witnesses representing six (6) other parties, each of whom had also filed written comments. Two (2) of these parties generally opposed the rules; the other parties generally supported the rules.

COMMENT: The Telecommunications Department Staff (Staff) recommends this section be implemented without change.

COMMENT: Since the commission has recently enacted 4 CSR 240-32.190, SBC reflects that additional rules for Caller ID blocking are unnecessary. SBC states that if it is determined that changes are needed to the Caller ID rules, such changes should be made to Chapter 32.

COMMENT: CenturyTel writes that this section is unnecessary as Caller ID rules are contained in Chapter 32.

COMMENT: Sprint opines that this section is duplicative of provisions contained in Chapter 32.

RESPONSE: We find that this section contains additional requirements unique to carrier-to-carrier delivery of Caller ID, which are not contained in Chapter 32. The additional requirements are necessary to prevent carriers from stripping Calling Party Number (CPN) in instances where originating callers block delivery of Caller ID. In such situations, the CPN is delivered to the terminating office but privacy indicators preclude delivery of the Caller ID to the called party. We will order this section implemented without change.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 29—Enhanced Record Exchange Rules

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.040 and 386.250, RSMo 2000, the commission withdraws a rule as follows:

4 CSR 240-29.070 Special Provisions for Wireless-Originated Traffic Transmitted over the LEC-to-LEC Network **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 3, 2005 (30 MoReg 58). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: The public comment period ended February 2, 2005, and the commission received written comments from the staff of the commission and from seven (7) other parties. Three (3) of these commenters generally opposed the rules; the other commenters generally supported the rules. A public hearing was held on February 9, 2005, when the commission heard testimony

from the staff of the commission and from eight (8) other witnesses representing six (6) other parties, each of whom had also filed written comments. Two (2) of these parties generally opposed the rules; the other parties generally supported the rules.

4 CSR 240-29.070(1)
COMMENT: T-Mobile, Nextel, and Cingular (Joint Wireless Carriers) state that this section acknowledges the inability of wireless carriers to comply with section (2) of this rule. Joint Wireless Carriers express that real time routing on demarcation point is impossible and in many cases the calling number has been ported. Joint Wireless Carriers contend this section is even more unreasonable given the blocking requirements in other aspects of this chapter.
RESPONSE: The commission determines that these matters are best addressed in interconnection agreements. Thus, we will withdraw this rule.

4 CSR 240-29.070(2)
COMMENT: SBC states that this section impermissibly interferes with its interconnection obligations as set forth in the Telecommunications Act. SBC states that incumbent local exchange carriers are required to provide interconnection to wireless carriers who request it for the transmission and routing of telephone exchange service or exchange access service. SBC also questions the commission's authority under Missouri law to impose such restrictions on wireless carriers.
COMMENT: Sprint states this section should be eliminated and refers to its previous comments.
COMMENT: Joint Wireless Carriers state this section would require "triple screening" and force comparison of cell sites to the telephone number being dialed. Joint Wireless Carriers again state that Missouri law prohibits the commission from enactment of this section. In footnote 36, Joint Wireless Carriers express confusion about the switching functions of local exchange and interexchange carriers, especially when a company holds both types of Missouri certificates of authority.
RESPONSE: The commission determines that these matters are best addressed in interconnection agreements. Thus, we will withdraw this rule.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 29—Enhanced Record Exchange Rules

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.040 and 386.250, RSMo 2000, the commission adopts a rule as follows:

4 CSR 240-29.080 Use of Terminating Record Creation for LEC-to-LEC Telecommunications Traffic **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 3, 2005 (30 MoReg 58–59). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The public comment period ended February 2, 2005, and the commission received written comments from the staff of the commission and from seven (7) other parties. Three (3) of these commenters generally opposed the rules; the other commenters generally supported the rules. A public hearing was held on February 9, 2005, when the commission heard testimony from the staff of the commission and from eight (8) other witnesses representing six (6) other parties, each of whom had also filed written comments. Two (2) of these parties generally opposed the rules; the other parties generally supported the rules.

COMMENT: Sprint recommends elimination of this rule in its entirety. Sprint opines that there is no demonstration or evidence to support this initiative. Sprint acknowledges that originating record-creation is not perfect; however, Sprint maintains that terminating record-creation is a solution that will lead to other problems. Sprint attributes a four hundred thousand dollars ($400,000) fiscal impact to this rule.
COMMENT: SBC states this section will create confusion, increase costs, and increase billing disputes. SBC opines that in many instances, terminating records cannot identify the appropriate originating party. SBC asserts that terminating recordings do not differentiate the originating switch owner from the competitor utilizing the switch; SBC offers UNE-P and Type I wireless traffic as examples. As a result, according to SBC, use of terminating records will cause improper billing.

SBC states that it will incur $1.78 million in equipment and labor expense to develop, reconcile, and process terminating created records. Additionally, according to SBC, it will incur approximately five hundred thousand dollars ($500,000) in annual personnel costs. SBC contends that Staff inappropriately excluded all of these reported costs in the fiscal impact statement. Instead of creating a terminating records system, SBC recommends the commission revise this section as follows:

> Terminating telecommunications companies may obtain billing records or other billing information from transiting carriers for use in billing the originating carrier. Transiting companies may obtain billing information from other transiting carriers or terminating carriers for use in billing the originating carrier. It is the responsibility of both transiting and terminating companies to issue accurate bills to the originating carrier. It is the responsibility of the originating carrier to (1) compensate the transiting carrier(s) for providing the transiting function; and (2) compensate the terminating carrier for providing the terminating function.

Socket Telecom, XO Communications, and Big River Telephone Company (Socket, XO, and Big River) state particular support for this rule, which permits use of terminating records to generate accurate billing invoices. Socket, XO, and Big River opine that the current practice of relying on originating records simply does not work in today's environment, especially when numbers are ported. Socket, XO, and Big River describe the process of originating record-creation, and cite to the use of the called party's NPA-NXX code as the basis for identifying the terminating carrier. Socket, XO and Big River state that such records are then used by the terminating carrier to generate exchange access bills to the originating carrier. Socket, XO, and Big River complain that such systems fall apart when numbers are ported between carriers, because the terminating carrier is not correctly identified by the NPA-NXX code. According to Socket, XO, and Big River, the result is that one (1) local exchange carrier receives payment to which it is not entitled, and another local exchange carrier fails to receive the compensation to which it is rightfully entitled. This situation is particularly onerous, according to Socket, XO, and Big River, because the two (2) involved local exchange carriers are direct competitors. Socket, XO, and Big River state that use of terminating records would enable the proper terminating carrier to generate its own billing records and receive payment for the calls it terminates. Socket, XO, and Big River state that this rule is a critical step in the right direction if Missouri is going to have facility-based competition.
COMMENT: The Telecommunications Department Staff (Staff) recommended this rule be implemented without change. Staff states the

current practice of creating records at an originating or tandem office does not recognize the many instances where the call terminates to a ported telephone number. Consequently, according to the Staff, originating and tandem-created billing records are frequently in error. Staff reflects that only the terminating carrier may know for certain where a telephone call physically terminates, and on whose network. Staff states its opinion that terminating carriers should have the ability to create accurate billing records.

Staff asserts its belief that number portability will challenge billing record-creation irrespective of whether the billing records are recorded at the beginning, in the middle, or at the end of a telephone call. Staff reminds us that it is customary in our economy for those providing a service to also bill for the service, and contrary to standard practice for those receiving a service to also bill for the service. Staff points to 4 CSR 240-29.100 as a dispute resolution process that has been established, and offers that rule as a mechanism to be used in the event number portability causes billing problems. Staff states the dispute resolution process is similar to the processes used in various interconnection agreements, and offers Sprint's Master Agreement as an example. Staff also points to SBC's Accessible Letter CLEC03-346 as evidence that SBC implemented a terminating record-creation process for local exchange carriers in its five (5)-state region on December 1, 2003. Lastly, the Staff opines that terminating record-creation is recognized by Sprint, and offers Sprint's Wireless Termination Service tariff as an example. For these reasons, the Staff supports accurate terminating record-creation wherever possible or appropriate.

COMMENT: The Small Telephone Company Group (STCG) states that its concerns regarding the accuracy of originating records have been well documented over the last five (5) years. The STCG asserts its support for the ability of terminating carriers to utilize information received from the originating and/or transiting carriers to prepare category 11-01-XX records to generate bills for traffic termination. The STCG opines that this rule provision is consistent with standard billing practices where service providers generate bills for the use of their services, and the STCG supports this rule.

COMMENT: The Missouri Independent Telephone Company Group (MITG) characterizes originating record-creation as the "fox guarding the henhouse" approach. The MITG states that for the last five (5) years its member companies have suffered the loss of compensation and increased collection expenses attendant with an originating billing records system. The MITG asserts that some originating records are not provided with individual call detail, which renders the terminating local exchange carriers incapable of reconciling billing records to its own switch recordings. The MITG points to Texas PUC Docket 21982 as recognizing the national economic practice whereby the party remitting a service is also the party to record and bill for the service it provides. According to the MITG, the Texas PUC ordered that the terminating carrier be authorized to bill from its own recordings because such terminating records impose less cost, and are more efficient and less burdensome that other systems. According to the MITG, allowing terminating carriers to bill from its own call information, rather than relying on upstream carriers to provide billing records, represents a needed improvement.

RESPONSE: We cannot accept the fiscal impact or problematic assumptions inherent in Sprint's comments. We note that Sprint's own interconnection agreements contemplate the use of terminating records creation. For example, paragraph 64.1 of Sprint's December 9, 2002 Master Interconnection Agreement states:

> 64 USAGE MEASUREMENT
>
> 64.1 Each party shall calculate terminating interconnection minutes of use *based on standard AMA recordings made within each party's network,* these recordings being necessary for each party to generate bills to the other party. (Emphasis added).

We thus conclude that Sprint has already put in place the systems necessary to record traffic and process billing invoices generated on the basis of terminating switch recordings.

We note that SBC's suggestion would require both transiting carriers and terminating carriers to issue *accurate* bills to originating carriers. We find it disconcerting that SBC's suggestion places no such requirement on the bills or records SBC issues to terminating carriers. We see nothing in the record before us to refute the comments of Socket, XO, and Big River that originating office and tandem office created billing records are frequently inaccurate because of ported numbers. We agree with the MITG that the ability of terminating carriers to bill from their own records, rather than relying on upstream carriers, represents a needed improvement. We note our June 10, 1999 Report and Order in Case No. TO-99-254 which characterized as a "worthwhile goal" the opportunity for terminating carriers to capture more information about calls terminated to them. We note that terminating record-creation has been examined and implemented in other jurisdictions such as Kansas and Texas. We note the revised arbitration award in Docket No. 21982 as establishing a terminating record-creation process in Texas. We note SBC's Accessible Letter CLEC03-346 implementing a terminating record-creation process in its five (5)-state area beginning on December 1, 2003. We concur with the Texas Commission's statements that there may be disagreement over the content and/or accuracy of a carrier's termination records and, as with the Texas Commission, we expect that such disputes will be settled among the parties. We also note that the Texas Commission has concluded that use of terminating records is a more efficient and less burdensome method to track the exchange of traffic, and that terminating records impose less cost upon terminating carriers. While the record before us is insufficient to make similar conclusions in Missouri, we do agree with the Staff and the Texas Commission's statements that it is customary in our economy for those providing a service to also bill for the service. We find antithetical to ordinary commerce the practice of permitting those incurring charges to also be those who generate the bill for services rendered.

We caution any carrier that may wish to engage in Category 11 record-creation based on information received at the terminating office that our rules require accurate bill rendition. We expect all carriers to produce accurate billing records irrespective of the location where the billing information is captured. When disputes arise, we expect parties to work together to resolve issues. When the parties cannot reach agreement, we invite those parties to avail themselves of the dispute resolution processes contained within the various interconnection agreements and/or our local interconnection rules.

We disagree that terminating records are any more inaccurate for recording UNE-P and Type I wireless calls than originating records or tandem created records. We note that all resellers, including UNE-P providers, are required by the North American Numbering Plan Administrator to obtain an Operating Carrier Number (OCN). Notwithstanding SBC's previous comments that the Federal Communications Commission (FCC) has eliminated UNE-P on a going-forward basis, we find that the addition of an OCN has eliminated the problem SBC attempts to explain. As was explained in the Task Force meetings, OCNs can be used to distinguish UNE-P providers from the incumbent providers. As has also been explained, in the affidavit of SBC witness McPhee in Case No. TO-2005-0166, carriers may also utilize the Local Exchange Routing Guide and the Local Number Portability ("LNP") database to help identify the appropriate party to bill. The commission would also note its expectation that wireless number portability has and will continue to reduce demand for Type I wireless interconnections. However, to the extent Type I connections may still be used, Type I wireless connections can be identified by an OCN in all but the smallest blocks of numbers. If, after implementing these measures, SBC still finds it difficult to identify Type I wireless calls, SBC is encouraged to work with industry participants to address issues surrounding the identification of Type I wireless connections. For example, SBC may want to explore the possibility of using SS7 parameters to identify responsible parties in much the same manner as the Jurisdiction Information Parameter (JIP) may be used to identify the appropriate jurisdiction.

Use of these and similar parameters will enable parties to work together to at first identify and, if necessary, refute any potential instance of false billing related to Type I wireless calls.

We note that our rule permitting terminating record-creation requires creation of Category 11-01-XX records. We also note that Category 11-01-XX records are the type of records long used by local exchange carriers to bill interexchange carriers for long distance traffic traversing the interexchange carrier network. We find this type of record to be widely used and the most accepted form of record-creation among all carriers. We also note that creation of terminating records is strictly voluntary according to our rule. Because implementation of terminating records is voluntary, and because all carriers are already using Category 11-01-XX records as an accepted basis for establishing billing invoices, we cannot accept that carriers will have any fiscal impact associated with our rule. This is especially true for SBC, because it has already implemented a terminating record-creation process in its five (5)-state area pursuant to the Texas arbitration award. We conclude that receiving an accurate invoice compiled from a Category 11 record generated at a terminating end office imposes no greater fiscal impact on SBC, Sprint, and CenturyTel than does a similar invoice compiled from information generated at a tandem office. Thus, we conclude SBC, Sprint, and CenturyTel will have no fiscal impact from this rule.

Lastly, we reject SBC's contention that use of terminating records will cause confusion, increase costs, and increase billing disputes. In particular, we reject as unsubstantiated SBC's claim of a $1.78M fiscal impact to develop, reconcile, and process terminating created records. We note SBC's replacement Missouri Section 271 Interconnection Agreement (M2A) offering to competitive local exchange carriers as posted on SBC's website. Specifically, "Attachment Compensation" contains the following offerings:

> 10.1 In SBC Missouri each party, unless otherwise agreed, will calculate terminating interconnection minutes of use based on standard switch recordings made within the terminating carrier's network for Section 251(b)(5) traffic, ISP bound traffic, and intraLATA toll traffic. *These terminating recordings are the basis for each party to generate bills to the originating carrier.* (Emphasis added).
>
> 10.1.2 Where CLEC is using terminating recordings to bill intercarrier compensation, SBC Missouri will provide the terminating Category 11-01-XX records by means of the Daily Usage File (DUF) to identify traffic that originates from an end user being served by a third party telecommunications carrier using an SBC Missouri non-resale offering whereby SBC Missouri provides the end office switching on a wholesale basis. *Such records will contain the Operating Company Number (OCN) of the responsible LEC-to-LEC network that originated the calls which CLEC may use to bill such originating carrier for MOUS terminated on CLECs network.* (Emphasis added).

From this document and the substantial record now before us, we conclude that SBC has implemented a system-wide process of terminating record-creation for traffic exchanged with competitive local exchange carriers. We also conclude that SBC's system obviously uses an OCN to account for UNE-P traffic, and that such system feeds UNE-P call transactions daily to competitors who use a terminating records creation process. Given the obvious extent to which SBC has already implemented a terminating records creation process in Missouri, we reject SBC's contention of a fiscal impact attributed to our rules.

We are also hesitant to accept the viewpoint of those who contend that our rules will create confusion. Because SBC has already implemented its terminating records creation process, any potential confusion should be directed elsewhere—not to our rules. Given SBC's practice of relying on terminating record-creation for traffic exchanged with competitive carriers, we see no reason not to extend the process to willing participants simply because they are incumbent carriers. We find that doing less might result in disparate treatment of incumbent carriers in Missouri because these carriers are not permitted to avail themselves of the M2A or similar interconnection agreements that SBC makes available to competitive local exchange carriers. We find that permitting incumbent carriers to avail themselves of the same record-creation processes as competitors will lessen the potential for disparate treatment. We will implement this rule without change.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 29—Enhanced Record Exchange Rules

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.040 and 386.250 RSMo 2000, the commission adopts a rule as follows:

4 CSR 240-29.090 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 3, 2005 (30 MoReg 59–61). Those sections of the proposed rule with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The public comment period ended February 2, 2005, and the commission received written comments from the staff of the commission and from seven (7) other parties. Three (3) of these commenters generally opposed the rules; the other commenters generally supported the rules. A public hearing was held on February 9, 2005, when the commission heard testimony from the staff of the commission and from eight (8) other witnesses representing six (6) other parties, each of whom had also filed written comments. Two (2) of these parties generally opposed the rules; the other parties generally supported the rules.

COMMENT: The Small Telephone Company Group (STCG) expresses support for this rule as requiring the timely provision of records and payments to terminating carriers. According to the STCG, these provisions are appropriate and consistent with common business practices.
COMMENT: The Telecommunications Department Staff (Staff) recommends this rule be implemented without change.
RESPONSE AND EXPLANATION OF CHANGE: We will implement this rule after making a change as discussed in our comments related to section (2).

4 CSR 240-29.090(2)
COMMENT: Sprint suggests eliminating this section as it is inconsistent with Sprint's PSC Mo. No. 26 Tariff.
COMMENT: SBC states this section is unnecessary, as the payment time frame for exchange access service invoices is stated in individual access tariffs. SBC suggests that in the event the commission goes forth with this section, this paragraph be amended to read: "The originating carrier shall submit payment of all amounts not disputed in good faith within thirty (30) days."
RESPONSE AND EXPLANATION OF CHANGE: Not all compensation occurring on the LEC-to-LEC network is subject to access tariffs. We find no material difference in the thirty (30) days referenced in this section and the thirty-one (31) days referenced in Sprint's tariff. Nevertheless, we will change our rule to reflect that payments are due in thirty-one (31) days and not the original thirty (30) days. We also acknowledge SBC's concern and will incorporate its suggestion to recognize the possibility of disputed amounts.

4 CSR 240-29.090(3)
COMMENT: The Staff supports this section and states a twelve (12)-month record retention period is consistent with other industry standards, and offers SBC's PSC Mo. No. 36 as an example.
COMMENT: SBC objects to a twelve (12)-month record retention period for billing records it creates. SBC states that the carrier creating the records should keep such records only so long as may be needed to retransmit the data if needed, and that carriers using the records to submit invoices should keep the records only for so long as that carrier deems necessary. SBC recommends reducing from twelve (12)-months to ninety (90) days the retention period for recording companies.
RESPONSE: We will order this section implemented as written. We find instructive the twelve (12)-month retention period outlined in SBC's access tariff. We can find no reason to implement industry standards for the LEC-to-LEC network which are not consistent with what SBC and the industry recognize as acceptable in the interexchange network.

4 CSR 240-29.090(4)
COMMENT: The STCG recommends addition of a new section to this rule to address residual billing. According to the STCG, addition of its suggested language will address the problem whereby terminating carriers assume one hundred percent (100%) of the risk for unidentified and uncompensated traffic. According to the STCG, a residual billing mechanism would also provide terminating carriers an appropriate procedure for relief in the event that unidentified and uncompensated traffic continues to flow over the LEC-to-LEC network. The STCG states that other state commissions have imposed similar residual billing obligations on large Bell Operating Companies, and offers the state of Michigan by way of example. The STCG's proposed language would first permit recording of total telecommunications traffic at an end office. The total minutes would then be compared to the sum of all recorded minutes as shown on Category 11-01-XX billing records received from transiting carriers. If the total minutes received exceeded the recorded minutes, the STCG's proposal would permit it to invoice the transiting carrier for the difference. The transiting carriers would then have sixty (60) days to produce Category 11-01-XX billing records or pay the terminating carriers for the "unidentified" traffic.
RESPONSE: We are unwilling to accept the STCG's suggestion to implement the residual billing mechanism suggested. We have previously declined to implement residual billing for the reasons stated in our Report and Order in Case No. TO-99-254, and we again decline for those same reasons. We will not permit measurement of total telecommunications traffic at a terminating end office to be used against total compensable minutes recorded in a tandem office because total telecommunications traffic recorded at an end office contains minutes of noncompensable traffic. It is improper to compare compensable calls recorded at a tandem switch to total minutes recorded at a terminating office that may include local calls, Metropolitan Calling Area (MCA) calls, incomplete calls, abandoned calls, calls to busy signals, calls to recorded announcements and other manner of noncompensable traffic. We note the STCG's comment defined this difference as "unidentified traffic." We caution carriers that the term "unidentified traffic" is defined in 4 CSR 240-29.100(3) as the difference between *compensable* minutes for which a call record is received and *compensable* minutes recorded at a terminating office. Our rules intentionally do not count non-compensable minutes of use as "unidentified."

In order for the STCG to count traffic as "unidentified," it must first determine the minutes of compensable records received and compare them to the compensable minutes terminated. Pursuant to 4 CSR 240-29.100(3), if the terminating carrier notes discrepancies between the two (2), it is encouraged to report the discrepancy to the relevant upstream tandem providers. In reporting instances of unidentified traffic, terminating carriers are required, again, pursuant to our rules, to provide the "ANI [Automatic Number Identification] and such other information relating to such unidentified traffic as is in its possession." We expect such other information to include, at minimum, the called number, time and date stamp, and trunk group information. Such information must be provided to upstream carriers on a per-call basis. Terminating carriers may not simply count up minutes on a random basis without consideration to such basic information as to whether or not the calls are even compensable. The STCG's proposal would place the burden on tandem carriers to prove calls were delivered to, for example, a busy signal. It is simply unnecessary as well as improper and inefficient to place such burdens on tandem providers. Our rules empower the small terminating carriers with the tools they need to monitor and better manage developments on their own network. Having provided such tools to them, we will not now permit the small carriers to simply sit back and mistakenly count calls to busy signals as unidentified traffic, thus forcing tandem carriers to disprove the allegation. We will implement our rules without the residual billing suggestion from the STCG.

4 CSR 240-29.090 Time Frame for the Exchange of Records, Invoices, and Payments for LEC-to-LEC Network Traffic

(2) Upon receiving a correct invoice requesting payment for terminating traffic placed on the LEC-to-LEC network, the originating carrier shall submit payment of all amounts not disputed in good faith within thirty-one (31) days to the telecommunications company that submitted the invoice.

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Division 240—Public Service Commission
Chapter 29—Enhanced Record Exchange Rules

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.040 and 386.250, RSMo 2000, the commission adopts a rule as follows:

4 CSR 240-29.100 Objections to Payment Invoices **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 3, 2005 (30 MoReg 62). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The public comment period ended February 2, 2005, and the commission received written comments from the staff of the commission and from seven (7) other parties. Three (3) of these commenters generally opposed the rules; the other commenters generally supported the rules. A public hearing was held on February 9, 2005, when the commission heard testimony from the staff of the commission and from eight (8) other witnesses representing six (6) other parties, each of whom had also filed written comments. Two (2) of these parties generally opposed the rules; the other parties generally supported the rules.

COMMENT: SBC opposes this rule as overly formal.
COMMENT: The Telecommunications Department Staff (Staff) recommends this rule be implemented without change. Staff states this rule defines the term "unidentified traffic" and establishes clear and expedited dispute resolution procedures involving receipt of such traffic. Staff opines that this rule encourages a thorough examination of billing problems and sets forth an intercarrier dispute resolution process whereby the parties may ultimately bring a dispute to the

commission in the event they are unable to resolve via informal dispute resolution. Staff describes a streamlined process which will permit a regulatory law judge to make a decision, which shall be the commission's decision, except that any party shall have twenty (20) days to request a full commission review of the judge's decision.

COMMENT: The Small Telephone Company Group (STCG) supports this rule because it establishes a dispute resolution procedure to resolve objections to invoices received from terminating carriers. The STCG states it supports the concept of a dispute resolution procedure that facilitates expeditious resolution of billing disputes and discrepancies.

COMMENT: The Missouri Independent Telephone Company Group (MITG) supports this rule as providing an expedited dispute resolution process applicable to disputed invoices as well as to unidentified traffic.

COMMENT: Sprint recommends elimination of this proposed rule. Sprint opines that carriers have long-established billing dispute resolution procedures. Without explanation, Sprint states that the rule seeks a change in the business relationship between tandem carriers and end office carriers.

RESPONSE: We will implement this rule without change. We disagree with Sprint's contention of a long-established billing dispute resolution procedure for transiting traffic. In fact, the billing relationship associated with traffic traversing the LEC-to-LEC network is a relatively recent development. This is especially true for transiting traffic. We find that the long-established dispute resolution referenced by Sprint is more applicable to the business relationship inherent to the interexchange carrier network. The business relationship inherent to the LEC-to-LEC network is not sufficient to have developed any experiences with a dispute resolution track record. This is especially so in a business relationship where, as with transiting traffic, the terminating carrier has no business relationship with the carrier responsible for invoice payment.

We also disagree with SBC's characterization of this rule as overly formal. What SBC characterizes as overly formal and convoluted we find clear, concise, and detailed enough to provide guidance to parties who wish to avail themselves of the dispute resolution process. Our rule is intended to provide for the timely resolution of billing disputes among the involved parties, without commission intervention. In the event parties are unable to resolve the dispute, our rule codifies the steps necessary to bring the matter to the commission's attention. Our rule contemplates an expedited hearing process, without the need for mandatory prefiled testimony. Our expedited process calls for a regulatory law judge to render a binding decision which may be appealed to the full commission at the discretion of one party or the other. We find this process is not overly complicated and we will implement this rule without change.

4 CSR 240-29.100(3)

COMMENT: SBC opposes the manner in which this section permits connecting carriers to report receipt of unidentified traffic. SBC states that mere notification is insufficient to conduct an investigation of unidentified traffic, and suggests expanding the rule to include sufficient information about each call the terminating carrier believes is unidentified. SBC also characterizes as impractical the notification requirements imposed on terminating tandem carriers. SBC states that, by definition, if a call is "unidentified," neither the terminating carrier nor the tandem carrier would know which upstream carrier to notify. SBC states that such requirement would require it to notify all carriers in the LATA in order to comply with this section. SBC concludes its written comments on the section by stating that a "thorough investigation" be conducted to determine if unidentified traffic is even an issue anymore.

RESPONSE: We will implement this section without change. SBC mischaracterizes this section as requiring an investigation based on a simple e-mail request to do so. In fact, our rule requires the objecting carrier to provide the Calling Party Number (CPN) and other such information as is in its possession to enable the tandem provider to investigate the unidentified traffic.

We also reject SBC's contention that this section is impractical because "unidentified traffic" is, by definition, "unidentified." SBC's definition suffers the same fatal flaw as the STCG's. This section of our rule defines "unidentified traffic" as a compensable call for which no Category 11-01-XX billing record was received. As we have explained in our response to the STCG, our rules ensure that terminating carriers will have to diagnose the CPN and other relevant factors to determine if a call is at first compensable. Then, on a per-call basis, the terminating carrier will be required to determine if a corresponding Category 11 billing record was received from the originating tandem provider. Only after establishing discrepancies between these facts may a terminating carrier characterize traffic as "unidentified" and report the information to the upstream tandem carrier for investigation. We reject SBC's contention that "unidentified" traffic means that upstream carriers are unknown. As we have stated throughout our responses, parties are expected to use the CPN parameter to aid in determining the responsible party.

Lastly, we reject SBC's contention that we should expend more time to conduct even more investigations to determine the prevalence of "unidentified traffic." We find that our rules provide the affected parties with the necessary tools to determine for themselves the amount of unidentified traffic that may be occurring on the LEC-to-LEC network. The ability to have separate trunk groups and the expectation that an unmodified CPN will be present on each call should provide terminating carriers the ability to identify "unidentified traffic," as we define the term. Past instances of unaccounted-for traffic have already been thoroughly documented and there is no need to conduct further investigations. We will implement this rule without change.

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Division 240—Public Service Commission
Chapter 29—Enhanced Record Exchange Rules

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.040 and 386.250, RSMo 2000, the commission withdraws a rule as follows:

4 CSR 240-29.110 Duty to File Tariffs for Compensable Telecommunications Traffic in the Absence of Commission—Approved Interconnection Agreements **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 3, 2005 (30 MoReg 63). The proposed rule is withdrawn.

SUMMARY OF COMMENTS: The public comment period ended February 2, 2005, and the commission received written comments from the staff of the commission and from seven (7) other parties. Three (3) of these commenters generally opposed the rules; the other commenters generally supported the rules. A public hearing was held on February 9, 2005, when the commission heard testimony from the staff of the commission and from eight (8) other witnesses representing six (6) other parties, each of whom had also filed written comments. Two (2) of these parties generally opposed the rules; the other parties generally supported the rules.

COMMENT: Sprint reports "no issues" with this rule.

COMMENT: The Telecommunications Department Staff (Staff) recommends this rule be implemented without change. Staff points to the Missouri Court of Appeals as upholding the concept of the filed tariff doctrine.

COMMENT: T-Mobile, Nextel, and Cingular (Joint Wireless Carriers) characterize tariffs as "futile."
RESPONSE: Due to actions of the Federal Communications Commission in its February 24, 2005 Report and Order in CC Docket No. 01-92, we will withdraw this rule in its entirety.

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ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.040 and 386.250, RSMo 2000, the commission adopts a rule as follows:

4 CSR 240-29.120 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 3, 2005 (30 MoReg 63–64). Those sections of the proposed rule with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The public comment period ended February 2, 2005, and the commission received written comments from the staff of the commission and from seven (7) other parties. Three (3) of these commenters generally opposed the rules; the other commenters generally supported the rules. A public hearing was held on February 9, 2005, when the commission heard testimony from the staff of the commission and from eight (8) other witnesses representing six (6) other parties, each of whom had also filed written comments. Two (2) of these parties generally opposed the rules; the other parties generally supported the rules.

COMMENT: T-Mobile, Nextel, and Cingular (Joint Wireless Carriers) state that it is unreasonable to block wireless calls. According to Joint Wireless Carriers, blocking rules prevent wireless carriers from providing their services. Joint Wireless Carriers recommend that blocking rules not apply to wireless traffic.
COMMENT: Sprint comments that the blocking process outlined in the rules inappropriately moves the legal burden of proof. Sprint cites those aspects of the rules that require an originating carrier to complain to the commission if it desires to refute the reasons it is given for having its traffic blocked.
COMMENT: SBC maintains that current tariffs already contain provisions sufficient for blocking traffic for nonpayment of tariff charges. SBC cites to small local exchange carrier wireless termination and access tariffs as examples. Without recommending specific language, SBC also requests the commission clarify that blocking authorized by these sections be limited to situations where the carrier to be blocked is directly interconnected to the originating tandem carrier.
COMMENT: The Small Telephone Company Group (STCG) supports this rule as an appropriate and necessary enforcement mechanism when carriers fail to pay for their traffic, provide proper records, or deliver originating caller identification to downstream carriers. However, the STCG states that it is inappropriate to make terminating carriers bear the cost burden.
COMMENT: The Missouri Independent Telephone Company Group (MITG) supports this rule and characterizes it as a comprehensive process for halting the transmission of traffic from carriers not in compliance with the rules.
COMMENT: The Staff recommends this rule be implemented without change. The Staff notes that traffic would not necessarily be blocked; rather, the traffic would likely be rerouted onto the facilities of an interexchange carrier. Staff states the blocking rules establish an orderly process for blocking traffic of carriers who do not pay their bills or comply with rules governing traffic on the LEC-to-LEC network. Staff states its belief that there are adequate safeguards in the blocking rules, and any decision to block traffic is ultimately left up to the commission. The Staff suggests the blocking provisions provide balance between the needs of consumers and those of telephone companies. Staff opines that the rules acknowledge the need for calls to traverse the network uninterrupted, while recognizing that all originating carriers have the duty to pay for sending transiting calls to another carrier.
RESPONSE: We find our blocking provisions necessary to prevent abuses of payment obligations. We again note that our rules would not actually block traffic to end users. Rather, our rules would block the ability of end users to receive calls over the LEC-to-LEC network. It is expected that affected carriers would use the facilities of interexchange carriers to terminate calls in the event these rules were implemented against a carrier.

4 CSR 240-29.120(7)
COMMENT: In the event the commission implements blocking rules, SBC recommends modification of this section to recognize that competitive local exchange carriers provide wholesale switching. Rather than identify UNE-P, SBC suggests more generic wording.
RESPONSE AND EXPLANATION OF CHANGE: We agree with SBC that this section should be modified to include the potential for competitive carriers to provide unbundled switching ports.

4 CSR 240-29.120 Blocking Traffic of Originating Carriers and/or Traffic Aggregators by Transiting Carriers

(7) It is recognized that at the time of call placement, transiting carriers cannot identify the traffic originated by a particular originating carrier, where that particular originating carrier and one (1) or more other originating carriers are using the same switch to originate traffic. Transiting carriers who desire to block traffic of a particular originating carrier of such a "shared" switch platform shall file a formal complaint with the commission seeking such blockage. All such formal complaints shall name the originating carrier whose traffic is sought to be blocked as well as the carrier or other entity whose switch is being used to originate the traffic. All such formal complaints shall be filed pursuant to the commission's procedures for filing formal complaints, and shall set forth complete details including, but not limited to, any violation of commission rules or Missouri statutes alleged to have occurred. Such formal complaint shall also state what action and relief the complainant seeks from the commission. Such requested relief may include complete blockage of the originating carrier using switching services provided by the incumbent local exchange carrier or other entity whose switch is being used. All such formal complaints shall request expedited consideration.

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ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.040 and 386.250, RSMo 2000, the commission adopts a rule as follows:

4 CSR 240-29.130 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 3, 2005 (30 MoReg 64–65). Those sections of the proposed rule with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The public comment period ended February 2, 2005, and the commission received written comments from the staff of the commission and from seven (7) other parties. Three (3) of these commenters generally opposed the rules; the other commenters generally supported the rules. A public hearing was held on February 9, 2005, when the commission heard testimony from the staff of the commission and from eight (8) other witnesses representing six (6) other parties, each of whom had also filed written comments. Two (2) of these parties generally opposed the rules; the other parties generally supported the rules.

COMMENT: The Telecommunications Department Staff (Staff) supports adoption of this rule without change.
COMMENT: Sprint opines that this rule inappropriately shifts the burden of proof.
COMMENT: The Small Telephone Company Group (STCG) states this rule is necessary and appropriate.
COMMENT: The Missouri Independent Telephone Company Group (MITG) states this rule is comprehensive and necessary.
RESPONSE: We disagree that placing blocking safeguards in our rule shifts the burden of proof. Our safeguards are designed to prevent a carrier's traffic from being blocked without the final authority of the commission. We agree that terminating carriers may initiate blocking procedures; however, affected carriers have an automatic right to appeal to the commission. We find such safeguards to be more extensive than the current practices outlined in various access tariffs. We decline to make changes to this rule other than those to section (11) as suggested by SBC.

4 CSR 240-29.130(10)
COMMENT: The STCG states that it is inappropriate to make terminating carriers bear the cost for blocking unidentified and uncompensated traffic. According to the STCG, it is more appropriate for the upstream carriers to bear the cost because the upstream carriers are the ones responsible for placing the traffic on the network. The STCG proposes wording that would permit terminating carriers to recover blocking costs from upstream carriers.
RESPONSE: As we have explained in previous orders, we believe that the carrier requesting blocking to occur should be the carrier responsible for paying for the blocking.

4 CSR 240-29.130(11)
COMMENT: SBC suggests this section should conform to its suggestions in section (7) of 4 CSR 240-29.120.
RESPONSE: We agree with SBC that section (11) of this rule should reference unbundled switch ports of competitors as well as SBC. We will modify section (11) to comport with SBC's suggestion.

4 CSR 240-29.130 Requests of Terminating Carriers for Originating Tandem Carriers To Block Traffic of Originating Carriers and/or Traffic Aggregators

(11) Nothing in sections (1) through (10) above shall require transiting carriers to block traffic of originating carriers using switching services provided by an incumbent local exchange carrier or other entity. It is recognized that, at the time of call placement, transiting carriers cannot identify the traffic originated by a particular originating carrier where that particular originating carrier and one (1) or more other originating carriers are using the same switch to originate traffic. Terminating carriers who desire to block the traffic of a particular originating carrier of such a "shared" switch platform shall file a formal complaint with the commission seeking such blockage. All such formal complaints shall name the originating carrier whose traffic is sought to be blocked, as well as the carrier or other entity whose switch is being used to originate the traffic. All such formal complaints shall be filed pursuant to the commission's procedures for filing formal complaints, and shall set forth complete details including, but not limited to, any violation of commission rules or Missouri statutes alleged to have occurred. Such formal complaint shall also state what action and relief the complainant seeks from the commission. Such requested relief may include complete blockage of the originating carrier using switching services provided by the incumbent local exchange carrier or other entity whose switch is being used. All such formal complaints shall request expedited consideration.

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ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.040 and 386.250, RSMo 2000, the commission adopts a rule as follows:

4 CSR 240-29.140 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 3, 2005 (30 MoReg 65–66). Those sections of the proposed rule with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The public comment period ended February 2, 2005, and the commission received written comments from the staff of the commission and from seven (7) other parties. Three (3) of these commenters generally opposed the rules; the other commenters generally supported the rules. A public hearing was held on February 9, 2005, when the commission heard testimony from the staff of the commission and from eight (8) other witnesses representing six (6) other parties, each of whom had also filed written comments. Two (2) of these parties generally opposed the rules; the other parties generally supported the rules.

COMMENT: Sprint opines that this rule inappropriately shifts the burden of proof.
COMMENT: The Telecommunications Department Staff (Staff) supports adoption of this rule without change.
COMMENT: The Small Telephone Company Group (STCG) states this rule is necessary and appropriate, although it is inappropriate for terminating carriers to bear the cost burden.
COMMENT: The Missouri Independent Telephone Company Group (MITG) states this rule is comprehensive and necessary.
RESPONSE: We decline to place blocking cost recovery on entities other than those who request blocking to occur. We will implement this rule without change.

4 CSR 240-29.140(2)
COMMENT: SBC recommends this section be modified by addition of the following sentence: "It is recognized that transit carriers can only pass originating caller identification to other transit carriers and terminating carriers to the extent it receives such information."

RESPONSE: We find that Calling Party Number (CPN) is an essential ingredient to determine the entity properly responsible for payment of call termination. The business relationship we have established relieves SBC, Sprint and CenturyTel of all primary and secondary financial responsibility for the traffic they choose to transit. Such business relationship leaves terminating carriers at complete financial risk for one hundred percent (100%) of the traffic delivered by transiting carriers. Given the business relationship and financial liability we have placed on terminating carriers, we find our CPN delivery requirement provides but a modicum of comfort to terminating carriers who bear one hundred percent (100%) percent of the risk. Especially in light of the substantial financial responsibility our business relationship places on terminating carriers, we conclude this requirement represents a *de minimis* intrusion on originating and transiting carriers. Transiting carriers are expected to only transit calls bearing CPN and we order implementation of this section without change.

4 CSR 240-29.140(4)
COMMENT: We received no comments on this section.
RESPONSE AND EXPLANATION OF CHANGE: Because we have eliminated use of the term "UNE-P" from other rules in this chapter, we find it necessary to eliminate it from this rule.

4 CSR 240-29.140(7)
COMMENT: As with 4 CSR 240-29.130(10), the STCG recommends changing language in this section which would permit the terminating carrier to recover blocking costs from upstream carriers.
RESPONSE: We again find that those carriers requesting blocking should be responsible for the costs of blocking. We decline to change this section.

4 CSR 240-29.140 Blocking Traffic of Transiting Carriers by Terminating Carriers

(4) Upon receipt of notice that its transiting traffic is subject to blocking by terminating carriers, transiting carriers shall notify all telecommunications companies for whom the transiting carrier is contractually obligated to transit traffic. Such notices shall include, but shall not be limited to, resellers of local exchange service and providers of shared switching platforms. Such notices shall also include, but shall not be limited to, all originating carriers, traffic aggregators, and other transiting carriers with whom the transiting carrier has established direct interconnection facilities. Such notices shall be sent via certified mail within seven (7) days from the receipt of notice from the terminating carrier.

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ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.040 and 386.250, RSMo 2000, the commission adopts a rule as follows:

4 CSR 240-29.150 Confidentiality **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 3, 2005 (30 MoReg 66–67). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The public comment period ended February 2, 2005, and the commission received written comments from the staff of the commission and from seven (7) other parties. Three (3) of these commenters generally opposed the rules; the other commenters generally supported the rules. A public hearing was held on February 9, 2005, when the commission heard testimony from the staff of the commission and from eight (8) other witnesses representing six (6) other parties, each of whom had also filed written comments. Two (2) of these parties generally opposed the rules; the other parties generally supported the rules.

COMMENT: SBC states that this rule is unnecessary. SBC maintains that most aspects of this rule have been codified in Chapter 33 of the commission's rules.
COMMENT: CenturyTel states that this rule should be eliminated as the subject matter is addressed in Chapter 33 of the commission's rules. CenturyTel opines that, if changes are needed, such changes should be made in Chapter 33.
COMMENT: Sprint recommends eliminating this rule because similar provisions are in Chapter 33 of the commission's rules.
COMMENT: The Telecommunications Department Staff (Staff) supports adoption of this rule without change.
RESPONSE: We find that this rule contains provisions not contained in Chapter 33 of our rules. We conclude that the specific confidentiality aspects of this rule are unique to intercompany billing purposes, and we order implementation of this rule without change.

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ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.040 and 386.250, RSMo 2000, the commission adopts a rule as follows:

4 CSR 240-29.160 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 3, 2005 (30 MoReg 67). Those sections of the proposed rule with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The public comment period ended February 2, 2005, and the commission received written comments from the staff of the commission and from seven (7) other parties. Three (3) of these commenters generally opposed the rules; the other commenters generally supported the rules. A public hearing was held on February 9, 2005, when the commission heard testimony from the staff of the commission and from eight (8) other witnesses representing six (6) other parties, each of whom had also filed written comments. Two (2) of these parties generally opposed the rules; the other parties generally supported the rules.

COMMENT: Sprint reports no issues with this rule.
COMMENT: The Telecommunications Department Staff (Staff) supports adoption of this rule without change.

RESPONSE: No changes will be made as a result of general comments to this rule. We will, however, modify our rule pursuant to SBC's comments on section (1) below.

4 CSR 240-29.160(1)

COMMENT: SBC recommends adding language which it says would bring this rule in line with language commonly found in commission-approved interconnection agreements.

RESPONSE AND EXPLANATION OF CHANGE: We agree with SBC that the audit provisions of our local interconnection rule should be more in line with industry standards as reflected in commission-approved interconnection agreements. We will adopt SBC's suggestions.

4 CSR 240-29.160 Audit Provisions

(1) A telecommunications company who receives records from another telecommunications company for billing may perform a comprehensive review of the record process utilized for providing billing records that are issued for payment of compensable traffic. These reviews may only be conducted once a year. A telecommunications company's right to access information for review purposes is limited to data not in excess of eighteen (18) months in age. Once specific data has been reviewed, it is not subject to further reviews. All information involved with the review shall be treated as strictly confidential and not be disclosed to a third party without the written consent of the party being reviewed.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 10—Nursing Home Program

ORDER OF RULEMAKING

By the authority vested in the Division of Medical Services under sections 198.401, 198.403, 198.406, 198.409, 198.412, 198.416, 198.418, 198.421, 198.424, 198.427, 198.431, 198.433, 198.436 and 208.201, RSMo 2000, and 198.439, RSMo Supp. 2004, the director amends a rule as follows:

13 CSR 70-10.110 Nursing Facility Reimbursement Allowance (NFRA) **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on February 1, 2005 (30 MoReg 272–275). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 26—Federally-Qualified Health Center Services

ORDER OF RULEMAKING

By the authority vested in the Division of Medical Services under sections 208.153 and 208.201, RSMo 2000, the director amends a rule as follows:

13 CSR 70-26.010 Medicaid Program Benefits for Federally-Qualified Health Center Services **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on February 15, 2005 (30 MoReg 383). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 10—Office of the Director
Chapter 33—Hospital and Ambulatory Surgical Center Data Disclosure

ORDER OF RULEMAKING

By the authority vested in the Missouri Department of Health and Senior Services under section 192.667, RSMo Supp. 2004, the department adopts a rule as follows:

19 CSR 10-33.050 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on March 1, 2005 (30 MoReg 444-452). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Comments were received from the Missouri Hospital Association, eleven (11) hospitals (both large and small), a chapter of the Association for Professionals in Infection Control and Epidemiology (APIC), a business health coalition, and an individual.

COMMENT: A number of objections were made regarding the reporting of surgical site infections (SSIs) for Cesarean sections because these procedures tend not to be elective surgeries, the risk adjustment has been developed only for study purposes, and because of the burden of the data requirements to report on this type of procedure. The hospitals suggested that abdominal hysterectomies be substituted for Cesarean sections. There were also concerns about reporting SSIs related to coronary artery bypass graft with chest incision only, due to the small number of these types of surgeries.
RESPONSE AND EXPLANATION OF CHANGE: The department agrees that Cesarean section should be dropped from the list for required reporting on SSIs at this time. In lieu of Cesarean section, abdominal hysterectomy was added to the list for reporting SSIs. The department also agrees that coronary artery bypass graft with chest incision only should be dropped from the list for required reporting on SSIs.

COMMENT: A number of objections were made to reporting on ventilator-associated pneumonia (VAP) because of problems with identifying these cases and the lack of reliability of outcome measures for VAPs. It was argued that process measures related to VAPs would be a better way to monitor quality improvement and patient safety, as recommended by the CDC's Healthcare Infection Control Practices Advisory Committee.

RESPONSE: The reporting of ventilator-associated pneumonia is required under section 192.667, RSMo Supp. 2004 and will remain in the rule. The department has not been given authority to collect process measures related to healthcare-associated infections (HAIs). No changes have been made to the rule as a result of this comment.

COMMENT: Several comments were made related to extending the reporting deadline in order to allow the hospitals more time to have staff trained on the National Healthcare Safety Network (NHSN) definitions and how to report infections using the reporting methods specified in the rule.
RESPONSE: The reporting deadline of July 1, 2005 will remain in effect in order to comply with section 192.667, RSMo Supp. 2004 which requires that the first report be published no later than December 31, 2006. No changes have been made to the rule as a result of this comment.

COMMENT: Several hospitals in the state are using an existing electronic system, internal or via a vendor, to collect infection data. The facilities requested that they be allowed to submit the required data directly from those systems to the department, as an alternative to using either the NHSN system or the reporting system provided by the department.
RESPONSE AND EXPLANATION OF CHANGE: The department agreed that this was an acceptable alternative method of reporting and has added the phrase, "in a format approved by the department," to section (8) of the rule.

COMMENT: Several correspondents indicated they were committed to assisting consumers in making decisions regarding their healthcare, saw this as an important beginning in creating protocols to enhance quality, patient safety, and reduce healthcare-associated infections, had respect for the state's flexibility and openness to other viewpoints, and appreciated efforts to make the process beneficial and meaningful.
RESPONSE: No changes have been made to the rule as a result of this comment.

COMMENT: Other concerns, not directly related to the proposed rule, included the manner in which the data will be reported and consumer education, the importance of training for infection control practitioners, and the lack of a requirement to report process measures.
RESPONSE: At this time the department does not have the statutory authority to make the requested changes. No changes have been made to the rule as a result of this comment.

19 CSR 10-33.050 Reporting of Healthcare-Associated Infection Rates by Hospitals and Ambulatory Surgical Centers

(1) The following definitions shall be used in the interpretation of this rule:

(B) Central line as defined by the CDC;

(D) Department means the Missouri Department of Health and Senior Services;

(E) Healthcare provider means hospitals as defined in section 197.020, RSMo, and ambulatory surgical centers (ASCs) as defined in section 197.200, RSMo;

(F) Intensive Care Unit (ICU) means coronary, medical, surgical, medical/surgical, pediatric, and neonatal intensive care units (NICU);

(G) National Healthcare Safety Network (NHSN) means the CDC nosocomial infection surveillance system;

(H) Neonatal Intensive Care Unit (NICU) and High Risk Nursery (HRN) are synonymous and mean that the infants in those units are critically ill and receive level III care as defined by the CDC;

(I) Nosocomial infection is defined in section 192.665(6), RSMo and is referred to as healthcare-associated infection (HAI) in this rule;

(J) Risk index means grouping patients who have operations according to the American Society of Anesthesiologists (ASA) score, length of procedure, wound class, and other criteria as defined by the CDC for the purpose of risk adjustment as required in section 192.667.3, RSMo;

(K) Surgical site infection (SSI) as defined by the CDC; and

(L) Ventilator-associated pneumonia (VAP) as defined by the CDC.

(2) All hospitals shall submit to the department data to compute HAI incidence rates on the following:

(B) SSIs from designated types of surgeries as set forth in section (4) of this rule, performed after December 31, 2005; and

(3) All ASCs shall submit to the department data to compute HAI incidence rates on SSIs from designated types of surgeries as set forth in section (5) of this rule, performed after December 31, 2005.

(4) Hospitals shall report SSIs by risk index related to a hip prosthesis, to an abdominal hysterectomy, and to a coronary artery bypass graft with both chest and donor site incisions performed after December 31, 2005.

(5) ASCs shall report SSIs by risk index related to breast surgery and herniorrhaphy performed after December 31, 2005.

(7) Healthcare providers may meet the HAI reporting requirements if they submit their data to the CDC NHSN or its successor system and if:

(D) The healthcare provider has policies and procedures to ensure that all HAIs as required by this rule are detected and reported. Such policies and procedures shall be consistent with appropriate guidelines of CDC, or the Society for Healthcare Epidemiology of America (SHEA), or the Association for Professionals in Infection Control and Epidemiology (APIC);

(8) If a healthcare provider chooses to not submit the required data to the CDC NHSN, the healthcare provider may meet the HAI reporting requirements by submitting to the department numerator and denominator data on forms provided by the department, or in a format approved by the department, for each of the infections specified in sections (2), (3), (4), and (5) and if:

(C) The healthcare provider has policies and procedures to ensure that all HAIs as required by this rule are detected and reported. Such policies and procedures shall be consistent with appropriate guidelines of CDC, or the SHEA, or the APIC;

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 25—Division of Administration
Chapter 36—Testing for Metabolic Diseases

ORDER OF RULEMAKING

By the authority vested in the director of the Department of Health and Senior Services under sections 701.322, RSMo Supp. 2004, 191.331 and 192.006, RSMo 2000, the director amends a rule as follows:

19 CSR 25-36.010 Testing for Metabolic and Genetic Disorders **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2005 (30 MoReg 453–454). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

This section may contain notice of hearings, correction notices, public information notices, rule action notices, statements of actual costs and other items required to be published in the *Missouri Register* by law.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

APPLICATION REVIEW SCHEDULE

The Missouri Health Facilities Review Committee has initiated review of the applications listed below. A decision is tentatively scheduled for July 18, 2005. These applications are available for public inspection at the address shown below:

Date Filed

Project Number: Project Name
City (County)
Cost, Description

05/03/05

#3712 HS: Ray County Memorial Hospital
Richmond (Ray County)
$1,009,360, Replace computerized tomography scanner

05/06/05

#3767 HS: All Saints Special Care Hospital
Chesterfield (St. Louis County)
$5,475,056, Establish 25-bed long term care hospital

#3771 HS: St. John's Mercy Medical Center
St. Louis (St. Louis County)
$3,990,000, Acquire linear accelerator

#3764 NS: Levering Regional Health Care Center
Hannibal (Marion County)
$3,720,630, Add 60 skilled nursing facility beds

#3770 HS: Saint Francis Medical Center
Cape Girardeau (Cape Girardeau County)
$1,800,000, Acquire computerized tomography scanner

#3768 HS: Missouri Baptist Medical Center
St. Louis (St. Louis County)
$1,840,000, Acquire magnetic resonance imaging unit

#3769 HS: Barnes-Jewish Hospital
St. Louis (St. Louis City)
$2,500,000, Acquire linear accelerator

Any person wishing to request a public hearing for the purpose of commenting on these applications must submit a written request to this effect, which must be received by June 9, 2005. All written requests and comments should be sent to:

Chairman
Missouri Health Facilities Review Committee
c/o Certificate of Need Program
915 G Leslie Boulevard
Jefferson City, MO 65101

For additional information contact
Donna Schuessler, (573)751-6403.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

EXPEDITED APPLICATION REVIEW SCHEDULE

The Missouri Health Facilities Review Committee has initiated review of the applications listed below. A decision is tentatively scheduled for June 21, 2005. These applications are available for public inspection at the address shown below:

Date Filed

Project Number: Project Name
City (County)
Cost, Description

05/06/05

#3765 NS: Frene Valley Geriatric and Rehabilitation Center
Owensville (Gasconade County)
$2,000,000, Replace 30 skilled nursing facility (SNF) beds

05/10/05

#3773 NS: The 5700 Properties, SNF, LLC
St. Louis (St. Louis County)
$8,400,000, Replace 98 SNF beds

#3774 HS: Barnes-Jewish West County Hospital
St. Louis (St. Louis County)
$1,935,000, Replace magnetic resonance imaging unit

Any person wishing to request a public hearing for the purpose of commenting on these applications must submit a written request to this effect, which must be received by June 10, 2005. All written requests and comments should be sent to:

Chairman
Missouri Health Facilities Review Committee
c/o Certificate of Need Program
915 G Leslie Boulevard
Jefferson City, MO 65101

For additional information contact
Donna Schuessler, (573)751-6403.

The Secretary of State is required by sections 347.141 and 359.481, RSMo 2000 to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript.

NOTICE OF DISSOLUTION OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST AIR PARK, LLC

On May 4, 2005, Air Park, LLC, filed Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State. You are hereby notified that if you believe you have a claim against Air Park, LLC, you must submit a claim to Rick J. Muenks, 333 Park Central East, Suite 505, Springfield, Missouri 65806. Claims must include (1) name and address of claimant; (2) amount of claim; (3) basis of claim; and (4) documentation of claim. By law, proceedings are barred unless commenced against the LLC within 3 years after the publication of this notice.

NOTICE OF DISSOLUTION OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST GRAND ROCK, L.L.C.

On April 29, 2005, 2005, GRAND ROCK, L.L.C., a Missouri limited liability company (the "Company"), filed a Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State. Claims against the Company should be mailed to GRAND ROCK, L.L.C., Attention: Theresa Irvin, MC: NC1-002-29-01, 101 South Tryon Street, Charlotte, North Carolina 28255-0001. Claims must include the name and address of the claimant, amount of the claim, basis for the claim and documentation of the claim. A claim against the Company will be barred unless a proceeding to enforce the claim is commenced within three years after the publication of this notice.

ARTICLES OF TERMINATION FOR
LIMITED LIABILITY COMPANY

1. The name of the limited liability company is: Racer's, L.L.C.

2. The date the limited liability company's articles of organization were filed: June 2, 2000

3. The reason for filing articles of termination is: Cessation of business.

4. The effective date of this document is the date it is filed by the Secretary of State of Missouri, unless a future date is indicated, as follows: N/A

5. On March 10, 2005 a notice of winding up for this L.L.C. was filed with the Secretary of State of Missouri disclosing the dissolution.

Rule Changes Since Update to Code of State Regulations

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*, citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year—27 (2002), 28 (2003), 29 (2004) and 30 (2005). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RUC indicates a rule under consideration, and F indicates future effective date.

Rule Number	Agency	Emergency	Proposed	Order	In Addition
	OFFICE OF ADMINISTRATION				
1 CSR 10	State Officials' Salary Compensation Schedule				27 MoReg 189 27 MoReg 1724 28 MoReg 1861 29 MoReg 1610
1 CSR 20-1.010	Personnel Advisory Board and Division of Personnel		30 MoReg 148	30 MoReg 1070	
1 CSR 20-3.010	Personnel Advisory Board and Division of Personnel		30 MoReg 148	30 MoReg 1070	
1 CSR 20-3.020	Personnel Advisory Board and Division of Personnel		30 MoReg 149	30 MoReg 1070	
1 CSR 20-4.020	Personnel Advisory Board and Division of Personnel		30 MoReg 1044		
	DEPARTMENT OF AGRICULTURE				
2 CSR 30-2.010	Animal Health	30 MoReg 139	30 MoReg 149	30 MoReg 1070	
2 CSR 30-2.040	Animal Health		30 MoReg 685		
2 CSR 80-5.010	State Milk Board		30 MoReg 1044		
2 CSR 100-7.010	Missouri Agricultural and Small Business Development Authority		30 MoReg 150	30 MoReg 989	
2 CSR 100-10.010	Missouri Agricultural and Small Business Development Authority		30 MoReg 151	30 MoReg 989	
	DEPARTMENT OF CONSERVATION				
3 CSR 10-4.117	Conservation Commission		30 MoReg 1112		
3 CSR 10-6.410	Conservation Commission		30 MoReg 441	30 MoReg 1072	
3 CSR 10-6.415	Conservation Commission		30 MoReg 1112		
3 CSR 10-6.535	Conservation Commission		30 MoReg 1113		
3 CSR 10-7.410	Conservation Commission		30 MoReg 1113		
3 CSR 10-9.110	Conservation Commission		30 MoReg 1114		
3 CSR 10-9.645	Conservation Commission		30 MoReg 1114		
3 CSR 10-10.744	Conservation Commission		30 MoReg 1115		
3 CSR 10-11.115	Conservation Commission		30 MoReg 1115		
3 CSR 10-12.109	Conservation Commission		30 MoReg 1115		
3 CSR 10-12.110	Conservation Commission		30 MoReg 1116		
3 CSR 10-12.115	Conservation Commission		30 MoReg 1116		
3 CSR 10-12.125	Conservation Commission		30 MoReg 1116		
3 CSR 10-12.140	Conservation Commission		30 MoReg 1117		
3 CSR 10-12.145	Conservation Commission		30 MoReg 1118		
3 CSR 10-12.150	Conservation Commission		30 MoReg 1119		
3 CSR 10-20.805	Conservation Commission		30 MoReg 1119		
	DEPARTMENT OF ECONOMIC DEVELOPMENT				
4 CSR 15-1.020	Acupuncturist Advisory Committee		30 MoReg 509		
4 CSR 15-1.030	Acupuncturist Advisory Committee		30 MoReg 509		
4 CSR 15-3.010	Acupuncturist Advisory Committee		30 MoReg 511		
4 CSR 30-5.030	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		This IssueR This Issue		
4 CSR 30-5.060	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		30 MoReg 6	30 MoReg 989	
4 CSR 30-5.080	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		This Issue		
4 CSR 30-8.020	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		This Issue		
4 CSR 30-10.010	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		This IssueR This Issue		
4 CSR 30-12.010	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		29 MoReg 2212	30 MoReg 989	
4 CSR 30-21.010	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		This Issue		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
4 CSR 40-3.011	Office of Athletics		This IssueR This Issue		
4 CSR 40-4.090	Office of Athletics		This IssueR This Issue		
4 CSR 40-5.030	Office of Athletics		This Issue		
4 CSR 60-1.025	State Board of Barber Examiners		30 MoReg 763		
4 CSR 60-2.015	State Board of Barber Examiners		30 MoReg 763		
4 CSR 60-2.040	State Board of Barber Examiners		30 MoReg 764		
4 CSR 60-3.015	State Board of Barber Examiners		30 MoReg 768		
4 CSR 70-2.032	State Board of Chiropractic Examiners		30 MoReg 769		
4 CSR 70-2.040	State Board of Chiropractic Examiners		30 MoReg 772		
4 CSR 70-2.060	State Board of Chiropractic Examiners		30 MoReg 775		
4 CSR 70-2.070	State Board of Chiropractic Examiners		30 MoReg 775		
4 CSR 70-2.080	State Board of Chiropractic Examiners		30 MoReg 775		
4 CSR 70-2.090	State Board of Chiropractic Examiners		30 MoReg 782		
4 CSR 70-3.010	State Board of Chiropractic Examiners		30 MoReg 782		
4 CSR 95-1.005	Committee for Professional Counselors		30 MoReg 8	30 MoReg 990	
4 CSR 95-1.010	Committee for Professional Counselors		30 MoReg 10R	30 MoReg 990R	
4 CSR 95-1.020	Committee for Professional Counselors		30 MoReg 10R 30 MoReg 10	30 MoReg 990R 30 MoReg 990	
4 CSR 95-1.030	Committee for Professional Counselors		30 MoReg 10R	30 MoReg 990R	
4 CSR 95-1.040	Committee for Professional Counselors		30 MoReg 11R	30 MoReg 991R	
4 CSR 95-1.050	Committee for Professional Counselors		30 MoReg 11	30 MoReg 991	
4 CSR 95-1.060	Committee for Professional Counselors		30 MoReg 15	30 MoReg 991	
4 CSR 95-2.010	Committee for Professional Counselors		30 MoReg 18R 30 MoReg 18	30 MoReg 991R 30 MoReg 991	
4 CSR 95-2.020	Committee for Professional Counselors		30 MoReg 19R 30 MoReg 20	30 MoReg 992R 30 MoReg 992	
4 CSR 95-2.021	Committee for Professional Counselors		30 MoReg 25	30 MoReg 992	
4 CSR 95-2.030	Committee for Professional Counselors		30 MoReg 27R 30 MoReg 27	30 MoReg 993R 30 MoReg 993	
4 CSR 95-2.040	Committee for Professional Counselors		30 MoReg 29R	30 MoReg 993R	
4 CSR 95-2.050	Committee for Professional Counselors		30 MoReg 29R	30 MoReg 993R	
4 CSR 95-2.060	Committee for Professional Counselors		30 MoReg 29R	30 MoReg 993R	
4 CSR 95-2.065	Committee for Professional Counselors		30 MoReg 29	30 MoReg 993	
4 CSR 95-2.070	Committee for Professional Counselors		30 MoReg 34R	30 MoReg 994R	
4 CSR 95-2.080	Committee for Professional Counselors		30 MoReg 34R	30 MoReg 994R	
4 CSR 95-3.010	Committee for Professional Counselors		30 MoReg 34R 30 MoReg 34	30 MoReg 994R 30 MoReg 994	
4 CSR 95-3.015	Committee for Professional Counselors		30 MoReg 35	30 MoReg 995	
4 CSR 95-3.020	Committee for Professional Counselors		30 MoReg 36R	30 MoReg 996R	
4 CSR 95-3.030	Committee for Professional Counselors		30 MoReg 37R	30 MoReg 996R	
4 CSR 95-3.040	Committee for Professional Counselors		30 MoReg 37R	30 MoReg 996R	
4 CSR 95-3.050	Committee for Professional Counselors		30 MoReg 37R	30 MoReg 996R	
4 CSR 95-3.060	Committee for Professional Counselors		30 MoReg 37R	30 MoReg 996R	
4 CSR 95-3.070	Committee for Professional Counselors		30 MoReg 38R	30 MoReg 996R	
4 CSR 95-3.080	Committee for Professional Counselors		30 MoReg 38R	30 MoReg 997R	
4 CSR 95-3.090	Committee for Professional Counselors		30 MoReg 38R	30 MoReg 997R	
4 CSR 95-3.100	Committee for Professional Counselors		30 MoReg 38R	30 MoReg 997R	
4 CSR 95-3.110	Committee for Professional Counselors		30 MoReg 39R	30 MoReg 997R	
4 CSR 95-3.120	Committee for Professional Counselors		30 MoReg 39R	30 MoReg 997R	
4 CSR 95-3.130	Committee for Professional Counselors		30 MoReg 39R	30 MoReg 997R	
4 CSR 95-3.140	Committee for Professional Counselors		30 MoReg 40R	30 MoReg 998R	
4 CSR 95-3.150	Committee for Professional Counselors		30 MoReg 40R	30 MoReg 998R	
4 CSR 95-3.160	Committee for Professional Counselors		30 MoReg 40R	30 MoReg 998R	
4 CSR 95-3.170	Committee for Professional Counselors		30 MoReg 40R	30 MoReg 998R	
4 CSR 95-3.180	Committee for Professional Counselors		30 MoReg 41R	30 MoReg 998R	
4 CSR 95-3.190	Committee for Professional Counselors		30 MoReg 41R	30 MoReg 998R	
4 CSR 95-3.200	Committee for Professional Counselors		30 MoReg 41R	30 MoReg 999R	
4 CSR 95-3.210	Committee for Professional Counselors		30 MoReg 41R	30 MoReg 999R	
4 CSR 95-3.220	Committee for Professional Counselors		30 MoReg 42R	30 MoReg 999R	
4 CSR 95-4.010	Committee for Professional Counselors		30 MoReg 42R	30 MoReg 999R	
4 CSR 100	Division of Credit Unions				30 MoReg 1081
4 CSR 110-2.071	Missouri Dental Board		30 MoReg 609		
4 CSR 110-2.090 4 CSR 110-2.170	Missouri Dental Board		30 MoReg 613R 30 MoReg 616		
4 CSR 110-2.230	Missouri Dental Board		30 MoReg 1048		
4 CSR 110-2.240	Missouri Dental Board		30 MoReg 616		
4 CSR 110-2.260	Missouri Dental Board		30 MoReg 1048		
4 CSR 110-2.240	Missouri Dental Board		30 MoReg 616		
4 CSR 145-1.040	Missouri Board of Geologist Registration		30 MoReg 783		
4 CSR 145-2.060	Missouri Board of Geologist Registration		30 MoReg 784R 30 MoReg 784		
4 CSR 150-2.050	State Board of Registration for the Healing Arts		30 MoReg 788		
4 CSR 150-2.080	State Board of Registration for the Healing Arts		29 MoReg 2216 30 MoReg 788	30 MoReg 999W	
4 CSR 150-2.125	State Board of Registration for the Healing Arts		30 MoReg 790		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
4 CSR 150-2.153	State Board of Registration for the Healing Arts		30 MoReg 619		
4 CSR 150-3.010	State Board of Registration for the Healing Arts		30 MoReg 791		
4 CSR 150-3.060	State Board of Registration for the Healing Arts		30 MoReg 622		
4 CSR 150-4.055	State Board of Registration for the Healing Arts		30 MoReg 791		
4 CSR 150-6.010	State Board of Registration for the Healing Arts		30 MoReg 622R 30 MoReg 622		
4 CSR 150-6.020	State Board of Registration for the Healing Arts		30 MoReg 623		
4 CSR 150-6.025	State Board of Registration for the Healing Arts		30 MoReg 624		
4 CSR 150-6.030	State Board of Registration for the Healing Arts		30 MoReg 624		
4 CSR 150-6.040	State Board of Registration for the Healing Arts		30 MoReg 625		
4 CSR 150-6.050	State Board of Registration for the Healing Arts		30 MoReg 625		
4 CSR 150-6.060	State Board of Registration for the Healing Arts		30 MoReg 625		
4 CSR 150-6.070	State Board of Registration for the Healing Arts		30 MoReg 626		
4 CSR 150-7.135	State Board of Registration for the Healing Arts		30 MoReg 626		
4 CSR 195-3.010	Division of Workforce Development		This IssueR This Issue		
4 CSR 195-3.020	Division of Workforce Development		This Issue		
4 CSR 220-1.010	State Board of Pharmacy		30 MoReg 42 30 MoReg 1119		
4 CSR 220-2.010	State Board of Pharmacy		30 MoReg 42 30 MoReg 1120		
4 CSR 220-2.020	State Board of Pharmacy		30 MoReg 43 30 MoReg 1120		
4 CSR 220-2.030	State Board of Pharmacy		30 MoReg 46	30 MoReg 999	
4 CSR 220-2.050	State Board of Pharmacy		30 MoReg 48 30 MoReg 1123		
4 CSR 220-5.030	State Board of Pharmacy		30 MoReg 48 30 MoReg 1123		
4 CSR 232-1.040	Missouri State Committee of Interpreters		30 MoReg 791		
4 CSR 232-2.030	Missouri State Committee of Interpreters		30 MoReg 792		
4 CSR 232-3.010	Missouri State Committee of Interpreters		30 MoReg 793		
4 CSR 232-3.030	Missouri State Committee of Interpreters		30 MoReg 793		
4 CSR 233-1.040	State Committee of Marital and Family Therapists		30 MoReg 511		
4 CSR 240-2.061	Public Service Commission		30 MoReg 687		
4 CSR 240-2.071	Public Service Commission		This Issue		
4 CSR 240-3.130	Public Service Commission		30 MoReg 627		
4 CSR 240-3.135	Public Service Commission		30 MoReg 628		
4 CSR 240-3.513	Public Service Commission		30 MoReg 151	30 MoReg 1000	
4 CSR 240-29.010	Public Service Commission		30 MoReg 49	This Issue	
4 CSR 240-29.020	Public Service Commission		30 MoReg 50	This Issue	
4 CSR 240-29.030	Public Service Commission		30 MoReg 52	This Issue	
4 CSR 240-29.040	Public Service Commission		30 MoReg 53	This Issue	
4 CSR 240-29.050	Public Service Commission		30 MoReg 53	This Issue	
4 CSR 240-29.060	Public Service Commission		30 MoReg 58	This Issue	
4 CSR 240-29.070	Public Service Commission		30 MoReg 58	This IssueW	
4 CSR 240-29.080	Public Service Commission		30 MoReg 59	This Issue	
4 CSR 240-29.090	Public Service Commission		30 MoReg 59	This Issue	
4 CSR 240-29.100	Public Service Commission		30 MoReg 62	This Issue	
4 CSR 240-29.110	Public Service Commission		30 MoReg 63	This IssueW	
4 CSR 240-29.120	Public Service Commission		30 MoReg 63	This Issue	
4 CSR 240-29.130	Public Service Commission		30 MoReg 64	This Issue	
4 CSR 240-29.140	Public Service Commission		30 MoReg 65	This Issue	
4 CSR 240-29.150	Public Service Commission		30 MoReg 66	This Issue	
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4 CSR 240-33.045	Public Service Commission		30 MoReg 573		
4 CSR 240-125.010	Public Service Commission		30 MoReg 365	30 MoReg 1000	
4 CSR 240-125.020	Public Service Commission		30 MoReg 366	30 MoReg 1000	
4 CSR 240-125.030	Public Service Commission		30 MoReg 366	30 MoReg 1000	
4 CSR 240-125.040	Public Service Commission		30 MoReg 367	30 MoReg 1000	
4 CSR 240-125.050	Public Service Commission		30 MoReg 370	30 MoReg 1001	
4 CSR 240-125.060	Public Service Commission		30 MoReg 370	30 MoReg 1001	
4 CSR 240-125.070	Public Service Commission		30 MoReg 373	30 MoReg 1001	
4 CSR 250-5.030	Missouri Real Estate Commission		30 MoReg 268	30 MoReg 1072	
4 CSR 263-2.045	State Committee for Social Workers		30 MoReg 796		
4 CSR 263-2.047	State Committee for Social Workers		30 MoReg 796		
4 CSR 267-2.020	Office of Tattooing, Body Piercing and Branding		30 MoReg 516		
	DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION				
5 CSR 50-340.110	Division of School Improvement		30 MoReg 797R		
5 CSR 100-200.030	Missouri Commission for the Deaf and Hard of Hearing		30 MoReg 519		
5 CSR 100-200.045	Missouri Commission for the Deaf and Hard of Hearing		30 MoReg 519R 30 MoReg 519		
5 CSR 100-200.150	Missouri Commission for the Deaf and Hard of Hearing		30 MoReg 520		
5 CSR 100-200.170	Missouri Commission for the Deaf and Hard of Hearing		30 MoReg 520		

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5 CSR 100-200.210	Missouri Commission for the Deaf and Hard of Hearing		30 MoReg 521		
5 CSR 100-200.220	Missouri Commission for the Deaf and Hard of Hearing		30 MoReg 522		
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7 CSR 10-9.010	Missouri Highways and Transportation Commission		30 MoReg 689		
7 CSR 10-9.020	Missouri Highways and Transportation Commission		30 MoReg 689		
7 CSR 10-9.030	Missouri Highways and Transportation Commission		30 MoReg 691		
7 CSR 10-9.040	Missouri Highways and Transportation Commission		30 MoReg 692		
7 CSR 10-9.050	Missouri Highways and Transportation Commission		30 MoReg 692		
7 CSR 10-9.060	Missouri Highways and Transportation Commission		30 MoReg 693		
7 CSR 10-25.010	Missouri Highways and Transportation Commission				30 MoReg 1177
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9 CSR 10-5.205	Director, Department of Mental Health		30 MoReg 270	30 MoReg 1072W	
9 CSR 10-5.206	Director, Department of Mental Health		30 MoReg 629		
9 CSR 25-3.030	Fiscal Management		30 MoReg 441	30 MoReg 1170	
9 CSR 30-3.132	Certification Standards		30 MoReg 444	30 MoReg 1170	
	DEPARTMENT OF NATURAL RESOURCES				
10 CSR 10-1.030	Air Conservation Commission		This Issue		
10 CSR 10-2.390	Air Conservation Commission		30 MoReg 797		
10 CSR 10-5.480	Air Conservation Commission		30 MoReg 818		
10 CSR 10-6.065	Air Conservation Commission		30 MoReg 153		30 MoReg 322
10 CSR 10-6.070	Air Conservation Commission		30 MoReg 635		
10 CSR 10-6.075	Air Conservation Commission		30 MoReg 636		
10 CSR 10-6.080	Air Conservation Commission		30 MoReg 638		
10 CSR 10-6.110	Air Conservation Commission		This Issue		
10 CSR 10-6.360	Air Conservation Commission		30 MoReg 522		
10 CSR 10-6.380	Air Conservation Commission		30 MoReg 549		
10 CSR 10-6.390	Air Conservation Commission		30 MoReg 553		
10 CSR 20-7.015	Clean Water Commission		30 MoReg 838		
10 CSR 20-7.031	Clean Water Commission		30 MoReg 843		
10 CSR 23-3.060	Geological Survey and Resource Assessment Division		30 MoReg 975		
10 CSR 23-3.100	Geological Survey and Resource Assessment Division	30 MoReg 755			
10 CSR 23-5.050	Geological Survey and Resource Assessment Division	30 MoReg 760			
10 CSR 40-10.085	Land Reclamation Commission		30 MoReg 1124		
10 CSR 90-2.020	State Parks		29 MoReg 1726		
10 CSR 140-2.020	Division of Energy				30 MoReg 574
	DEPARTMENT OF PUBLIC SAFETY				
11 CSR 30-7.020	Office of the Director		30 MoReg 163	30 MoReg 1001	
11 CSR 40-5.110	Divison of Fire Safety		30 MoReg 1128		
11 CSR 45-1.090	Missouri Gaming Commission		30 MoReg 376		
11 CSR 45-5.190	Missouri Gaming Commission		30 MoReg 977		
11 CSR 45-5.200	Missouri Gaming Commission		30 MoReg 376		
11 CSR 45-5.210	Missouri Gaming Commission		30 MoReg 980		
11 CSR 45-1.090	Missouri Gaming Commission		30 MoReg 376		
11 CSR 45-9.030	Missouri Gaming Commission		30 MoReg 982		
11 CSR 45-30.025	Missouri Gaming Commission		30 MoReg 67	30 MoReg 1001	
11 CSR 45-30.030	Missouri Gaming Commission		30 MoReg 68	30 MoReg 1001	
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11 CSR 45-30.050	Missouri Gaming Commission		30 MoReg 69R	30 MoReg 1002R	
11 CSR 45-30.060	Missouri Gaming Commission		30 MoReg 69	30 MoReg 1002	
11 CSR 45-30.070	Missouri Gaming Commission		30 MoReg 69	30 MoReg 1003	
11 CSR 45-30.135	Missouri Gaming Commission		30 MoReg 70	30 MoReg 1172	
11 CSR 45-30.140	Missouri Gaming Commission		30 MoReg 70	30 MoReg 1003	
11 CSR 45-30.155	Missouri Gaming Commission		30 MoReg 70	30 MoReg 1003	
11 CSR 45-30.160	Missouri Gaming Commission		30 MoReg 71R	30 MoReg 1004R	
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11 CSR 45-30.175	Missouri Gaming Commission		30 MoReg 71	30 MoReg 1004	
11 CSR 45-30.180	Missouri Gaming Commission		30 MoReg 72	30 MoReg 1004	
11 CSR 45-30.200	Missouri Gaming Commission		30 MoReg 73	30 MoReg 1005	
11 CSR 45-30.205	Missouri Gaming Commission		30 MoReg 73	30 MoReg 1006	
11 CSR 45-30.210	Missouri Gaming Commission		30 MoReg 73	30 MoReg 1006	

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11 CSR 45-30.220	Missouri Gaming Commission		30 MoReg 74R	30 MoReg 1006R	
11 CSR 45-30.235	Missouri Gaming Commission		30 MoReg 74	30 MoReg 1006	
11 CSR 45-30.240	Missouri Gaming Commission		30 MoReg 74R	30 MoReg 1006R	
11 CSR 45-30.270	Missouri Gaming Commission		30 MoReg 75	30 MoReg 1007	
11 CSR 45-30.280	Missouri Gaming Commission		30 MoReg 75	30 MoReg 1008	
11 CSR 45-30.290	Missouri Gaming Commission		30 MoReg 76R	30 MoReg 1008R	
11 CSR 45-30.300	Missouri Gaming Commission		30 MoReg 76R	30 MoReg 1008R	
11 CSR 45-30.340	Missouri Gaming Commission		30 MoReg 76	30 MoReg 1008	
11 CSR 45-30.350	Missouri Gaming Commission		30 MoReg 77R	30 MoReg 1009R	
11 CSR 45-30.355	Missouri Gaming Commission		30 MoReg 77	30 MoReg 1173	
11 CSR 45-30.370	Missouri Gaming Commission		30 MoReg 78	30 MoReg 1009	
11 CSR 45-30.525	Missouri Gaming Commission		30 MoReg 78	30 MoReg 1010	
11 CSR 45-30.545	Missouri Gaming Commission		30 MoReg 79	30 MoReg 1010	
11 CSR 45-30.575	Missouri Gaming Commission		30 MoReg 79	30 MoReg 1010	
11 CSR 45-30.600	Missouri Gaming Commission		30 MoReg 80		
11 CSR 75-14.030	Peace Officer Standards and Training Program		30 MoReg 163	30 MoReg 1011	
11 CSR 80-9.020	Missouri State Water Patrol		30 MoReg 555		
	DEPARTMENT OF REVENUE				
12 CSR 10-2.195	Director of Revenue		30 MoReg 982R		
12 CSR 10-5.050	Director of Revenue		30 MoReg 164R	30 MoReg 1072R	
12 CSR 10-5.060	Director of Revenue		30 MoReg 164R	30 MoReg 1072R	
12 CSR 10-5.070	Director of Revenue		30 MoReg 164R	30 MoReg 1072R	
12 CSR 10-5.075	Director of Revenue		30 MoReg 164R	30 MoReg 1073R	
12 CSR 10-5.545	Director of Revenue		30 MoReg 165R	30 MoReg 1073R	
12 CSR 10-5.550	Director of Revenue		30 MoReg 165R	30 MoReg 1073R	
12 CSR 10-5.555	Director of Revenue		30 MoReg 165R	30 MoReg 1073R	
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12 CSR 10-11.120	Director of Revenue		30 MoReg 166R	30 MoReg 1074R	
12 CSR 10-11.130	Director of Revenue		30 MoReg 166R	30 MoReg 1074R	
12 CSR 10-11.140	Director of Revenue		30 MoReg 167R	30 MoReg 1074R	
12 CSR 10-23.460	Director of Revenue		30 MoReg 167	30 MoReg 1175	
12 CSR 10-24.050	Director of Revenue		30 MoReg 1051		
12 CSR 10-24.428	Director of Revenue		30 MoReg 1051		
12 CSR 10-24.444	Director of Revenue		30 MoReg 1052		
12 CSR 10-24.474	Director of Revenue		30 MoReg 1052		
12 CSR 10-25.050	Director of Revenue		30 MoReg 167	30 MoReg 1175	
12 CSR 10-26.040	Director of Revenue		30 MoReg 168	30 MoReg 1175W	
12 CSR 10-41.010	Director of Revenue	30 MoReg 5	30 MoReg 80	30 MoReg 1074	
12 CSR 10-104.040	Director of Revenue		30 MoReg 83	30 MoReg 1175	
12 CSR 10-107.100	Director of Revenue		This Issue		
12 CSR 10-110.400	Director of Revenue		30 MoReg 86	30 MoReg 1175	
12 CSR 10-114.100	Director of Revenue		30 MoReg 90	30 MoReg 1074	
12 CSR 10-400.200	Director of Revenue	30 MoReg 357	30 MoReg 379	30 MoReg 1176	
12 CSR 10-400.250	Director of Revenue		30 MoReg 93	30 MoReg 1176	
12 CSR 10-405.100	Director of Revenue	30 MoReg 603	30 MoReg 639		
12 CSR 10-405.200	Director of Revenue	30 MoReg 604	30 MoReg 643		
12 CSR 10-500.210	Director of Revenue		30 MoReg 1052		
	DEPARTMENT OF SOCIAL SERVICES				
13 CSR 35-20.010	Children's Division		29 MoReg 2261	30 MoReg 1011	
13 CSR 35-30.010	Children's Division	30 MoReg 233	30 MoReg 271	30 MoReg 1075	
13 CSR 35-50.010	Children's Division	30 MoReg 234	30 MoReg 272	30 MoReg 1075	
13 CSR 40-19.020	Division of Family Services	29 MoReg 1637	29 MoReg 1729		
13 CSR 40-110.020	Division of Family Services	30 MoReg 605R	30 MoReg 647R		
13 CSR 40-110.030	Division of Family Services		30 MoReg 561		
13 CSR 70-3.020	Division of Medical Services		30 MoReg 1130		
13 CSR 70-3.030	Division of Medical Services		This Issue		
13 CSR 70-3.160	Division of Medical Services		30 MoReg 1130		
13 CSR 70-4.050	Division of Medical Services		This Issue		
13 CSR 70-4.080	Division of Medical Services		30 MoReg 1131		
13 CSR 70-4.100	Division of Medical Services	30 MoReg 1109	30 MoReg 1137		
13 CSR 70-4.110	Division of Medical Services		This Issue		
13 CSR 70-5.010	Division of Medical Services		This Issue		
13 CSR 70-10.015	Division of Medical Services	30 MoReg 761	30 MoReg 982		
13 CSR 70-10.080	Division of Medical Services	30 MoReg 761	30 MoReg 987		
13 CSR 70-10.110	Division of Medical Services	30 MoReg 235	30 MoReg 272	This Issue	
13 CSR 70-20.200	Division of Medical Services		30 MoReg 171	30 MoReg 1011	
13 CSR 70-26.010	Division of Medical Services		30 MoReg 383	This Issue	
13 CSR 70-91.010	Division of Medical Services		30 MoReg 1139		
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15 CSR 30-50.040	Secretary of State		30 MoReg 172	30 MoReg 1011	
15 CSR 30-54.195	Secretary of State		30 MoReg 173	30 MoReg 1012	
15 CSR 40-3.120	State Auditor	29 MoReg 1639R	29 MoReg 2261		
15 CSR 40-3.130	State Auditor	29 MoReg 1639	29 MoReg 2262		

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15 CSR 40-3.140	State Auditor	29 MoReg 1651	29 MoReg 2274		
15 CSR 40-3.150	State Auditor	29 MoReg 1661	29 MoReg 2284		
15 CSR 40-3.160	State Auditor	29 MoReg 1673	29 MoReg 2296		
15 CSR 60-13.060	Attorney General		30 MoReg 693		
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16 CSR 50-2.110	The County Employees' Retirement Fund		30 MoReg 647		
16 CSR 50-10.050	The County Employees' Retirement Fund		30 MoReg 1139		
	DEPARTMENT OF HEALTH AND SENIOR SERVICES				
19 CSR 10-33.050	Office of the Director		30 MoReg 444	This Issue	
19 CSR 20-1.025	Division of Environmental Health and Communicable Disease Prevention		30 MoReg 647		
19 CSR 20-1.060	Division of Environmental Health and Communicable Disease Prevention		30 MoReg 1056R		
19 CSR 20-2.010	Division of Environmental Health and Communicable Disease Prevention		30 MoReg 1056R		
19 CSR 20-2.030	Division of Environmental Health and Communicable Disease Prevention		30 MoReg 1056R		
19 CSR 20-3.050	Division of Environmental Health and Communicable Disease Prevention		30 MoReg 1141R 30 MoReg 1141		
19 CSR 20-20.080	Division of Environmental Health and Communicable Disease Prevention		30 MoReg 1056		
19 CSR 20-50.005	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 140	30 MoReg 173	30 MoReg 1075	
19 CSR 20-50.010	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 141	30 MoReg 174	30 MoReg 1075	
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19 CSR 20-50.030	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 144	30 MoReg 180	30 MoReg 1076	
19 CSR 20-50.035	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 145	30 MoReg 183	30 MoReg 1076	
19 CSR 20-50.040	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 145	30 MoReg 185	30 MoReg 1076	
19 CSR 25-36.010	Division of Administration		30 MoReg 453	This Issue	
19 CSR 30-82.050	Division of Health Standards and Licensure		29 MoReg 2305		
19 CSR 30-86.012	Division of Health Standards and Licensure		29 MoReg 2307	30 MoReg 725	
19 CSR 30-86.032	Division of Health Standards and Licensure		29 MoReg 2308	30 MoReg 725	
19 CSR 30-86.042	Division of Health Standards and Licensure		29 MoReg 2309		
19 CSR 60-50	Missouri Health Facilities Review Committee				30 MoReg 1081 This Issue
19 CSR 73-2.050	Missouri Board of Nursing Home Administrators		This Issue		
	DEPARTMENT OF INSURANCE				
20 CSR	Medical Malpractice				28 MoReg 489 29 MoReg 505 30 MoReg 481
20 CSR	Sovereign Immunity Limits				27 MoReg 2319 28 MoReg 2265 30 MoReg 108
20 CSR 200-6.600	Financial Examination		30 MoReg 698R		
20 CSR 300-2.200	Market Conduct Examinations		30 MoReg 988		
20 CSR 400-1.020	Life, Annuities and Health		30 MoReg 1068		
20 CSR 400-2.170	Life, Annuities and Health		29 MoReg 1755		
20 CSR 400-3.650	Life, Annuities and Health	This Issue	This Issue		
20 CSR 400-10.100	Life, Annuities and Health		30 MoReg 1159		
20 CSR 700-1.145	Licensing	30 MoReg 1043	30 MoReg 1068		
20 CSR 700-6.100	Licensing	29 MoReg 2209	29 MoReg 1587	30 MoReg 388	
20 CSR 700-6.100	Licensing	29 MoReg 2209	29 MoReg 1587	30 MoReg 388	
20 CSR 700-6.150	Licensing	29 MoReg 2209	29 MoReg 1590	30 MoReg 388	
20 CSR 700-6.160	Licensing		29 MoReg 1593	30 MoReg 389	
20 CSR 700-6.170	Licensing		29 MoReg 1597	30 MoReg 389	
20 CSR 700-6.200	Licensing		29 MoReg 1597	30 MoReg 389	
20 CSR 700-6.250	Licensing		29 MoReg 1598	30 MoReg 389	
20 CSR 700-6.300	Licensing		29 MoReg 1598	30 MoReg 389	

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21 CSR 10-1.010	Director and Board of Trustees		30 MoReg 1161		
21 CSR 10-1.020	Director and Board of Trustees		30 MoReg 1161		
21 CSR 10-1.030	Director and Board of Trustees		30 MoReg 1162		
21 CSR 10-2.010	Director and Board of Trustees		30 MoReg 1162		
21 CSR 10-3.010	Director and Board of Trustees		30 MoReg 1167		
21 CSR 10-4.010	Director and Board of Trustees		30 MoReg 1168		
21 CSR 10-4.020	Director and Board of Trustees		30 MoReg 1168		
	MISSOURI CONSOLIDATED HEALTH CARE PLAN				
22 CSR 10-2.010	Health Care Plan	30 MoReg 237R 30 MoReg 237	30 MoReg 275R 30 MoReg 275	30 MoReg 1077R 30 MoReg 1077	
22 CSR 10-2.020	Health Care Plan	30 MoReg 240R 30 MoReg 240	30 MoReg 280R 30 MoReg 280	30 MoReg 1077R 30 MoReg 1077	
22 CSR 10-2.030	Health Care Plan	30 MoReg 243R 30 MoReg 243	30 MoReg 283R 30 MoReg 283	30 MoReg 1077R 30 MoReg 1077	
22 CSR 10-2.045	Health Care Plan	30 MoReg 244R 30 MoReg 244	30 MoReg 283R 30 MoReg 284	30 MoReg 1078R 30 MoReg 1078	
22 CSR 10-2.055	Health Care Plan	30 MoReg 245R 30 MoReg 245	30 MoReg 284R 30 MoReg 284	30 MoReg 1078R 30 MoReg 1078	
22 CSR 10-2.070	Health Care Plan	30 MoReg 246R 30 MoReg 246	30 MoReg 285R 30 MoReg 285	30 MoReg 1078R 30 MoReg 1078	
22 CSR 10-2.075	Health Care Plan	30 MoReg 248R 30 MoReg 248	30 MoReg 286R 30 MoReg 287	30 MoReg 1079R 30 MoReg 1079	
22 CSR 10-2.080	Health Care Plan	30 MoReg 249R 30 MoReg 250	30 MoReg 288R 30 MoReg 288	30 MoReg 1079R 30 MoReg 1079	
22 CSR 10-3.010	Health Care Plan	30 MoReg 250	30 MoReg 289	30 MoReg 1079	
22 CSR 10-3.020	Health Care Plan	30 MoReg 253	30 MoReg 291	30 MoReg 1079	
22 CSR 10-3.030	Health Care Plan	30 MoReg 256	30 MoReg 294	30 MoReg 1080	
22 CSR 10-3.070	Health Care Plan	30 MoReg 257	30 MoReg 297	30 MoReg 1080	
22 CSR 10-3.075	Health Care Plan	30 MoReg 258	30 MoReg 298	30 MoReg 1080	
22 CSR 10-3.080	Health Care Plan	30 MoReg 259	30 MoReg 299	30 MoReg 1080	

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		Publication	Expires
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2 CSR 70-11.040	Bakanae of Rice Exterior Quarantine	Next Issue	November 23, 2005
Department of Economic Development			
Public Service Commission			
4 CSR 240-31.010	Definitions	Next Issue	February 15, 2006
4 CSR 240-31.050	Eligibility for Funding—Low-Income Customers and Disabled Customers	Next Issue	February 15, 2006
Department of Natural Resources			
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10 CSR 23-3.100	Sensitive Areas	30 MoReg 755	September 27, 2005
10 CSR 23-5.050	Construction Standards for Closed-Loop Heat Pump Wells	30 MoReg 760	September 27, 2005
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Director of Revenue			
12 CSR 10-41.010	Annual Adjusted Rate of Interest	30 MoReg 5	June 29, 2005
12 CSR 10-400.200	Special Needs Adoption Tax Credit	30 MoReg 357	July 15, 2005
12 CSR 10-405.100	Homestead Preservation Credit—Procedures	30 MoReg 603	September 15, 2005
12 CSR 10-405.200	Homestead Preservation Credit—Qualifications and Amount of Credit	30 MoReg 604	September 15, 2005
Department of Social Services			
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13 CSR 35-30.010	Voluntary Placement Agreement Solely for the Purpose of Accessing Mental Health Services and Treatment for Children Under Age Eighteen (18)	30 MoReg 233	June 30, 2005
13 CSR 35-50.010	Accreditation as Evidence for Meeting Licensing Requirements	30 MoReg 234	June 30, 2005
Family Support Division			
13 CSR 40-110.020	Federal Income Tax Refund Offset Fee	30 MoReg 605	September 25, 2005
Division of Medical Services			
13 CSR 70-4.100	Preventing Medicaid Payment of Expenses Used to Meet Spenddown	30 MoReg 1109	October 31, 2005
13 CSR 70-10.015	Prospective Reimbursement Plan for Nursing Facility Services	30 MoReg 761	September 27, 2005
13 CSR 70-10.080	Prospective Reimbursement Plan for HIV Nursing Facility Services	30 MoReg 761	September 27, 2005
13 CSR 70-10.110	Nursing Facility Reimbursement Allowance	30 MoReg 235	June 29, 2005
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Division of Environmental Health and Communicable Disease Prevention			
19 CSR 20-50.005	Definitions	30 MoReg 140	June 29, 2005
19 CSR 20-50.010	Eligibility Requirements for Pharmacies, Hospitals and Nonprofit Clinics to Receive Donated Prescription Drugs	30 MoReg 141	June 29, 2005
19 CSR 20-50.015	Eligibility Requirements for Recipients in the Program	30 MoReg 141	June 29, 2005
19 CSR 20-50.020	Standards and Procedures for Donating Prescription Drugs	30 MoReg 142	June 29, 2005
19 CSR 20-50.025	Standards and Procedures for Accepting Donated Prescription Drugs	30 MoReg 143	June 29, 2005
19 CSR 20-50.030	Standards and Procedures for Inspecting and Storing Donated Prescription Drugs	30 MoReg 144	June 29, 2005
19 CSR 20-50.035	Standards and Procedures for Dispensing Donated Prescription Drugs	30 MoReg 145	June 29, 2005
19 CSR 20-50.040	Record Keeping Requirements	30 MoReg 145	June 29, 2005
Department of Insurance			
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20 CSR 400-3.650	Medicare Supplement Insurance Minimum Standards Act	This Issue	February 2, 2006
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20 CSR 700-1.145	Demonstrating Incompetence, Untrustworthiness or Financial Irresponsibility in the Conduct of Variable Life and Variable Annuity Business by Insurance Producers	30 MoReg 1043	January 1, 2006
20 CSR 700-6.100	Fees and Renewals—Bail Bond Agents, General Bail Bond Agents and Surety Recovery Agents	29 MoReg 2209	June 29, 2005
20 CSR 700-6.150	Initial Basic Training for Bail Bond Agents, General Bail Bond Agents and Surety Recovery Agents	29 MoReg 2209	June 29, 2005
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22 CSR 10-2.010	Definitions	30 MoReg 237	June 29, 2005

22 CSR 10-2.010	Definitions	30 MoReg 237	June 29, 2005
22 CSR 10-2.020	Membership Agreement and Participation Agreement	30 MoReg 240	June 29, 2005
22 CSR 10-2.020	Subscriber Agreement and General Membership Provisions	30 MoReg 240	June 29, 2005
22 CSR 10-2.030	Contributions	30 MoReg 243	June 29, 2005
22 CSR 10-2.030	Contributions	30 MoReg 243	June 29, 2005
22 CSR 10-2.045	Co-Pay and PPO Plan Summaries	30 MoReg 244	June 29, 2005
22 CSR 10-2.045	Plan Utilization Review Policy	30 MoReg 244	June 29, 2005
22 CSR 10-2.055	Co-Pay and PPO Plan Benefit Provisions and Covered Charges	30 MoReg 245	June 29, 2005
22 CSR 10-2.055	Medical Plan Benefit Provisions and Covered Charges	30 MoReg 245	June 29, 2005
22 CSR 10-2.070	Coordination of Benefits	30 MoReg 246	June 29, 2005
22 CSR 10-2.070	Coordination of Benefits	30 MoReg 246	June 29, 2005
22 CSR 10-2.075	Review and Appeals Procedure	30 MoReg 248	June 29, 2005
22 CSR 10-2.075	Review and Appeals Procedure	30 MoReg 248	June 29, 2005
22 CSR 10-2.080	Miscellaneous Provisions	30 MoReg 249	June 29, 2005
22 CSR 10-2.080	Miscellaneous Provisions	30 MoReg 250	June 29, 2005
22 CSR 10-3.010	Definitions	30 MoReg 250	June 29, 2005
22 CSR 10-3.020	Subscriber Agreement and General Membership Provisions	30 MoReg 253	June 29, 2005
22 CSR 10-3.030	Public Entity Membership Agreement and Participation Period	30 MoReg 256	June 29, 2005
22 CSR 10-3.070	Coordination of Benefits	30 MoReg 257	June 29, 2005
22 CSR 10-3.075	Review and Appeals Procedure	30 MoReg 258	June 29, 2005
22 CSR 10-3.080	Miscellaneous Provisions	30 MoReg 259	June 29, 2005

Executive Orders	Subject Matter	Filed Date	Publication
	2005		
05-01	Rescinds Executive Order 01-09	January 11, 2005	30 MoReg 261
05-02	Restricts new lease and purchase of vehicles, cellular phones, and office space by executive agencies	January 11, 2005	30 MoReg 262
05-03	Closes state's Washington D.C. office	January 11, 2005	30 MoReg 264
05-04	Authorizes Transportation Director to issue declaration of regional or local emergency with reference to motor carriers	January 11, 2005	30 MoReg 266
05-05	Establishes the 2005 Missouri State Government Review Commission	January 24, 2005	30 MoReg 359
05-06	Bans the use of video games by inmates in all state correctional facilities	January 24, 2005	30 MoReg 362
05-07	Consolidates the Office of Information Technology to the Office of Administration's Division of Information Services	January 26, 2005	30 MoReg 363
05-08	Consolidates the Division of Design and Construction to Division of Facilities Management, Design and Construction	February 2, 2005	30 MoReg 433
05-09	Transfers the Missouri Head Injury Advisory Council to the Department of Health and Senior Services	February 2, 2005	30 MoReg 435
05-10	Transfers and consolidates in-home care for elderly and disabled individuals from the Department of Elementary and Secondary Education and the Department of Social Services to the Department of Health and Senior Services	February 3, 2005	30 MoReg 437
05-11	Rescinds Executive Order 04-22 and orders the Department of Health and Senior Services and all Missouri health care providers and others that possess influenza vaccine adopt the Center for Disease Control and Prevention, Advisory Committee for Immunization Practices expanded priority group designations as soon as possible and update the designations as necessary	February 3, 2005	30 MoReg 439
05-12	Designates members of staff with supervisory authority over selected state agencies	March 8, 2005	30 MoReg 607
05-13	Establishes the Governor's Advisory Council for Plant Biotechnology	April 26, 2005	30 MoReg 1110
05-14	Establishes the Missouri School Bus Safety Task Force	May 17, 2005	This Issue
	2004		
04-01	Establishes the Public Safety Officer Medal of Valor, and the Medal of Valor Review Board	February 3, 2004	29 MoReg 294
04-02	Designates staff having supervisory authority over agencies	February 3, 2004	29 MoReg 297
04-03	Creates the Missouri Automotive Partnership	January 14, 2004	29 MoReg 151
04-04	Creates the Missouri Methamphetamine Education and Prevention Task Force	January 27, 2004	29 MoReg 154
04-05	Establishes a Missouri Methamphetamine Treatment Task Force	January 27, 2004	29 MoReg 156
04-06	Establishes a Missouri Methamphetamine Enforcement and Environmental Protection Task Force	January 27, 2004	29 MoReg 158
04-07	Establishes the Missouri Commission on Patient Safety and supercedes Executive Order 03-16	February 3, 2004	29 MoReg 299
04-08	Transfers the Governor's Council on Disability and the Missouri Assistive Technology Advisory Council to the Office of Administration	February 3, 2004	29 MoReg 301
04-09	Requires vendors to disclose services performed offshore. Restricts agencies in awarding contracts to vendors of offshore services	March 17, 2004	29 MoReg 533
04-10	Grants authority to Director of Department of Natural Resources to temporarily waive regulations during periods of emergency and recovery	May 28, 2004	29 MoReg 965
04-11	Declares regional state of emergency because of the need to repair electrical outages by various contractors, including a Missouri contractor. Allows temporary exemption from federal regulations	May 28, 2004	29 MoReg 967
04-12	Declares emergency conditions due to severe weather in all Northern and Central Missouri counties	June 4, 2004	29 MoReg 968
04-13	Declares June 11, 2004 to be day of mourning for President Ronald Reagan	June 7, 2004	29 MoReg 969
04-14	Establishes an Emancipation Day Commission. Requests regular observance of Emancipation Proclamation on June 19	June 17, 2004	29 MoReg 1045
04-15	Declares state of emergency due to lost electrical service in St. Louis region	July 7, 2004	29 MoReg 1159
04-16	Orders a special census be taken in the City of Licking	July 23, 2004	29 MoReg 1245
04-17	Declares that Missouri implement the Emergency Mutual Aid Compact (EMAC) agreement with the State of Florida	August 18, 2004	29 MoReg 1347

Executive Orders	Subject Matter	Filed Date	Publication
04-19	Implements the EMAC with the State of Florida, activates the EMAC plan, and authorizes the use of the Missouri National Guard	September 10, 2004	29 MoReg 1430
04-20	Reestablishes the Poultry Industry Committee	September 14, 2004	29 MoReg 1432
04-21	Directs the creation of the Forest Utilization Committee within the Missouri Department of Conservation	September 14, 2004	29 MoReg 1434
04-22	Requests health care providers limit influenza vaccinations to high risk persons. Orders various actions by providers, Missouri Department of Health and Senior Services, and Attorney General's Office regarding influenza vaccine supply.	October 25, 2004	29 MoReg 1683
04-23	Creates the Forest Utilization Committee within the Missouri Department of Conservation. Supersedes and rescinds Executive Order 04-21	October 22, 2004	29 MoReg 1685
04-24	Rescinds Executive Order 03-15	October 22, 2004	29 MoReg 1687
04-25	Rescinds Executive Order 03-27	October 22, 2004	29 MoReg 1688
04-26	Authorizes Adjutant General to recognize Noncommissioned Officers with a First Sergeant's ribbon	November 1, 2004	29 MoReg 1791
04-27	Closes state offices Friday November 26, 2004	November 1, 2004	29 MoReg 1792
04-28	Closes state offices Monday, January 10, 2005	December 6, 2004	29 MoReg 2256
04-29	Rescinds Executive Order 04-22	January 4, 2005	30 MoReg 147

The rule number and the MoReg publication date follow each entry to this index.

RULEMAKING 1-2-3
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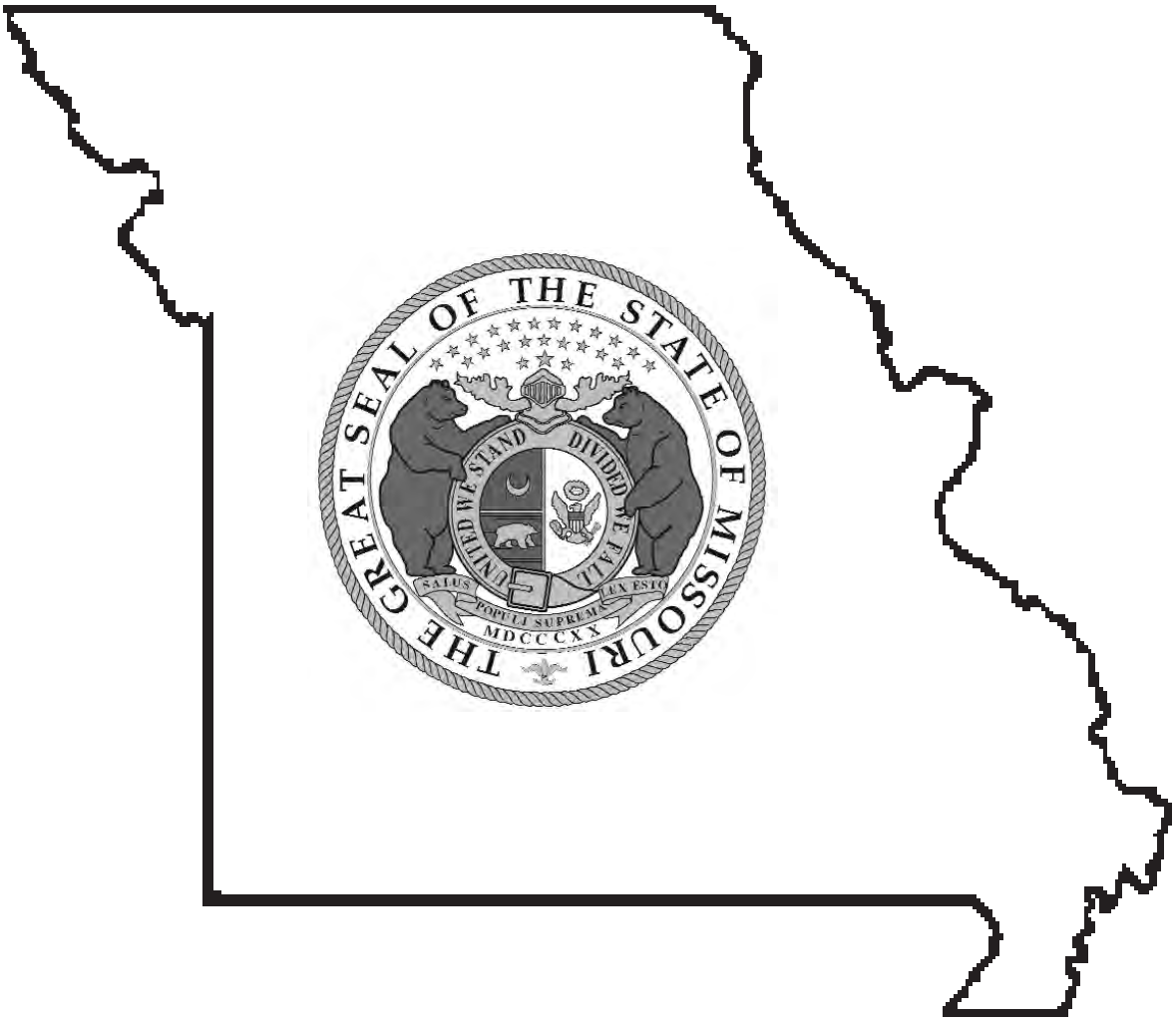

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